ARMY SERVICE FORCES

CONFERENCE

ON THE

DEPARTMENT OF RECONDITIONING SCHOOL FOR PERSONNEL SERVICES

5 JANUARY, 1945

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FRIDAY

5 January 1945

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Lt. Col. Jensen Presiding

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ROSTER

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Proceedings Of The Conference

5 January 1945.

Morning Session

COL. JENSEN: Today we are going to try to show you a bird's-eye view of the reconditioning courses at the School for Personnel Services.

First, a word about the school. This school is a Class 4 installation under the direct control of G-1, ASF. General Dalton is proud of his school, usually visits it once a month, and is a tremendous help to the school and its problems. The oldest department at the present time is the A and R Department, which trains officers for special service, operates under the technical advice of the Special Service Division, ASF. The second oldest course is the I and E course, Information and Education, formerly known as the Orientation Education course, which operates under the Information and Education Division, ASF. We also have the Reconditioning Course, and the newest one is the Course in Personal Affairs. There are many advantages in this arrangement of four different courses, all, in a sense, dealing with different aspects of personnel problems in the Army--Special Services, Information and Education, Reconditioning, and Personal Affairs.

We have also been very fortunate in maintaining close liaison with the Separation and Classification School at Fort Dix. We have provided a speaker for each of their classes, and they have provided a speaker for each of ours. So one thing that you can accomplish here at the school is this: we can introduce the student to the allied agencies that he will find in the field and in the hospitals, working in the same general direction.

Woodrow Wilson General Hospital is 34 miles away, and we have the opportunity to take the student body in Reconditioning to that hospital for one day. We break them into four groups and take them, a fourth each day. This gives the many student who have never seen a military hospital at least an opportunity to see a cantonment type standard general hospital, and to see the rudiments of reconditioning.

I might explain just a word about how the Course in Reconditioning is set up here. We have two departments, Educational Reconditioning and the Physical Reconditioning. I am the Director of the School: Major Joseph V. Reed is the Executive Officer; Major Lorensen is the Chief of the Educational Reconditioning Department, and Capt. Solomon is the Chief of the Physical Reconditioning Department.

In educational reconditioning we also have Capt. Gamser, Capt. Gunn, Lt. Rees, Lt. Morgan, Lt. Campora, Lt. McCarty. I have as an assistant Lt. Ferret, MC.

In the Physical Reconditioning Department, in addition to Capt. Solomon, the director, Lt. Vire, Lt. Fry, Lt. Gerlach; and Mr. Pennock is a civilian employee from Springfield College, an expert teacher of anatomy and physiology of muscles--exercise; he handles that part of our curriculum.

In order to allow each individual in the course, in the school, on the faculty, to become very familiar with an individual field in addition to the over-all picture of reconditioning, faculty members are assigned fields for investigation. For example, Capt. Gamser, who was originally an economist, is studying the problems of small business and the problems of the service trades, and trying to pick out from that study things that can be of use in educational reconditioning in a hospital situation, to point men back to that type of activity.

Capt. Gunn is a well qualified engineer, who has had experience--extensive experience--in technical training as a civilian, investigates the technical fields for us. Lt. Rees, agriculture; Lt. Morgan, military training; Lt. Campora, general investigation; Lt. McCarty handles the PE for the WACS in the school, also investigates matters dealing with occupational therapy, arts and crafts, and recreation in hospitals. Likewise the physical reconditioning class. The faculty is broken into sections. One of the large blocks of instruction in educational reconditioning is Army orientation. We were very fortunate to get from the I and E Division here in the school a very capable officer in this field. After coming with us he went out in the hospitals and visited debarkation hospitals, standard general hospitals, of

various types, and studied the orientation problems in those hospitals. That officer is Lt. Sprague. He handles the I & E work for both educational reconditioning and physical reconditioning.

A little later we will pass out the detailed programs of instruction, one for each course. You may take them with you.

You will also find at your space this publication, "Why, When, and How of Reconditioning," as taught at the school, which, when you have time to read it over will give you a fairly good resume of what we have here.

I might point out that this is an ASF school, that our curriculum and program of instruction is supervised and approved by ASF training as well as by The Surgeon General, and the school is run as all ASF training schools are run. The instruction that actually goes on here will be demonstrated to you today. You will attend one typical formal class; there has been no alteration made in the material to be presented for your benefit.

You will also attend typical gym activities in the gym and physical reconditioning fields.

Gradually we have evolved a philosophy of how to teach educational reconditioning and how to build up a concept of what the mission is in the student's mind.

The mission, of course, is laid down by The Surgeon General, but the problem of how to go about getting the concept over to the students is our mission. I might say that the little folder which we all got from Cushing General Hospital explains our approach about as well as anything that I know of. We feel that the man must first be oriented to the hospital, and his personal affairs taken care of. Then he must have some programming done, and we feel that separation and classification or other counselling agencies--military counselling agencies in the hospitals, such as personal affairs, can help in this phase of the work.

Then, we feel that educational reconditioning must step in and try to make as much as possible of the time spent in hospital useful in accomplishing the goals he wants to accomplish. He must sieze upon his motivations. If he is to return to military service, that may not be his over-all lifelong plan, but if that is his immediate responsibility and he understands that, you will find he will be interested in military education, to better prepare him to meet his coming jobs. If he is going back to civilian life, then, early counselling, early direction in the hospital makes his educational reconditioning meaningful to him.

One other thing that we do is to put over the concept of a philosophy and psychology of sickness, and how it changes the man's reaction to his problems and his environment.

I want to call to your attention a little book that has just recently come to my hand "And Now to Live Again" by Betsy Barton, which I believe is the best thing I have ever read on what happens to an individual's mind and outlook when they become the unfortunate victim of a serious accident.

I want to turn the program over now to Major Lorenzen who will present a brief summary of one of the very important blocks of instruction, organization and administration.

MAJOR LORENZEN: This morning I am going to talk about a block of hours we have in this course known as Organization and Administration. They deal specifically with the organization and administration of the reconditioning program in the hospital, not to be confused with school organization.

Now, the development of the course is going to be incomplete because I can't possibly expect to cover in 35 minutes what we take 26 hours to do, but I think you can get the flavor of what we are trying to do in these 26 hours in the ensuing 35 minutes.

These hours attempt to break reconditioning down into simple things. Like any other science or pseudo science, we have built up quite a terminology in this business in the last few months, and, believe me, to newcomers, it is very confusing.

So, breaking reconditioning down into simple things is a contribution to our students. The confusion that I am referring to does exist among students, not only the uninitiated, but the men that come to us with experience. How does this confusion come about? Well, it is quite simple. A man comes in from the Fifth Service Command. He moves in next door to someone from the Ninth Service Command. One says to the other, "We use patient officers in our program."

"You do? Well, we don't do that. They don't like that out our way."

"Why not?"

"Well, the Department does all the work."

"Have you got enough people to do that?"

"Well we have got a hundred patients in our hospital at the present time and five officers and 15 enlisted men to do the job in reconditioning."

And the other fellow looks startled and says: "We have 1500 patients and only one officer and three enlisted men. How come?"

"Well didn't you read Circular 73?"

"I think I have."

Then it goes on from there--the disparity in operational level in reconditioning is astounding to us here. Twice as many patients, one third as many personnel to run the program.

Then the poor little WAC who is straight out of basic listens to that and she is really confused.

So to tackle the whole problem, we break the business down into four major areas: the functional organization of reconditioning personnel. That is, who does what, and where do we get them; then, the second thing is program planning and content--what goes into this thing, anyway? Third and fourth, War Department directives, and funds for facilities and equipment.

I am going to confine myself to the first two; Capt. Gamser, this afternoon, will take up the second two.

Now, I would like to add three more reasons for this confusion that weren't apparent in the illustration I gave you. First of all, let me tell you that this field is new and there is a dearth of tried and tested experience. Secondly, we have the unique problem here of integrating the principles and practices of--well, let's call it professional education--with the practices of Army medicine, and to us old school teachers that is quite a jolt. Then, the third thing is the problem of reorienting the attitudes of the student toward education, from one of courses and credits and remunerative skills, to one of mental and physical therapy. That means quite a shift in the mental process of the student.

The first step, then, is to make a functional analysis of the personnel in reconditioning. We point up the dozens of duties that must be performed by reconditioning personnel such as running a PA system, scheduling, briefing discussion leaders, interviewing patients, training interviewers, preparing promotional material.

We take Circular 73 and analyze it to show what it provides for a hospital of a given size. Then, we compare that with the jobs to be done. That immediately points out the necessity of using other hospital agencies, such as special services chaplain, personal affairs, separation counsellors, and so forth. It also points out the necessity of contacting and utilizing other community resources. And we spend considerable time tapping the class for their experiences.

Well, now, how do you go at your community? What have you gotten out of it? Do you know of any other hospital that has gotten something else other than that which you have gotten?

Then, when they run out, we start adding ours that we have accumulated from eight classes. You see, we have a pretty good over-all picture of the scope of reconditioning activities, because we have had pretty nearly every general hospital in the country represented by a student here, and hundreds of station and regional hospitals.

Then, we lead into the concept of the interdependence of educational reconditioning and physical reconditioning, their functions, and how the complete specialization of function may probably breed sterility in function in the last analysis.

By sample scheduling, we show how economy of personnel can be practiced if we don't make too hard and fast a separation between ER and PR. There has been a growing tendency in the field to split those two things so far apart that the left hand doesn't know what the right hand is doing, and they are working in competition with one another in some places.

Now, when you get into the advanced reconditioning, you definitely are sterilizing you program if the two do not work hand in hand all the way through. I wish I had time to develop that theme a little more, but let's lead into the next thing.

Finally, in this phase of the organization and administration, we bring up the use of patients as a supplement to Circular 73. We use the term "ward reconditionin leaders." We discuss it from the angle of using patients, enlisted men or officers, or both. We cite cases of where this system of using officer patients or enlisted patients has failed miserably; then, on the other hand, we cite cases of where it has been a success. When we set about to try to analyze the reasons for the failure on the whole, we can break the failures down into two or three main items.

From what we have seen here, the first one is improper selection, orientation and training of those patients that are selected as ward reconditioning leaders. The second thing is, once you have selected them, not having clearly defined jobs for them to do which they consider worthy of their time and effort. Too many men have been pulled into the program as patients and given very insignificant things to do in the hospital in the hopes that that was the way to start. Well, in most cases where we have traced that through we have found that it ends in miserable failure. The men do not develop any confidence in the program for which they are working if their tasks are not of a worthy character.

Now, into the program planning phase, we set up two principles underlying program planning and they are as follows: first, that no preconceived completely standardized program for all hospitals is desired. Notice the phrase "completely standardized for all hospitals." Notice the phrase "completely standardized for all hospitals." Second, that certain basic elements should be present in all programs, but that their emphasis should vary. What are these common elements? We recognize 5--5 major areas.

Now, from here on I am talking about educational reconditioning alone. I am leaving out considerations of program planning in physical reconditioning because that will be taken up by the PR men later this afternoon.

The first of the five common elements that we think should be present in an educational reconditioning program is guidance, second is orientation, third is military education, fourth is elective education, a term that we have coined here to indicate the wide-spread academic, type of course, and fifth, recreation. Those are the five elements.

I would like to break each one down into a little more detail so that you have a correct impression of what we are talking about.

First, guidance. Guidance to us in program planning means a control factor for all the other four. The guidance program will consist of personal social guidance military reclassification, vocational guidance, and educational guidance.

Col. Jensen has already mentioned the fact that the personal social guidance comes first and, until you get that area cleaned up, progress in the others is going to be very, very small. It is one thing to set up the types of guidance and it is

another thing to find the personnel and the organization to do it. We make suggestions along the line of the separation and classification officer such as has been outlined for the convalescent hospitals; an organization like that, using the personal affairs officer and Red Cross and sometimes the chaplain, to make an effective guidance organization. As I said before, it becomes a control measure of the other four.

I will mention orientation only in passing because Lt. Sprague will take it up in greater detail immediately following this presentation, to say that it is divided into an introductory phase and a basic phase: The introductory, orientation to the hospital and to medical care, and finally the basic conduct of the war, the adjustment to civilian life, the things that we have been discussing around here for the last two days.

Military education I will come back to, but let me break it down into two areas now: tactical and technical developments and, second, advanced and refresher skills.

Now, the elective education. I must break it down into academic, such as high school and college courses, and to pre-vocational, such as business, trades, and agriculture. And third into work production.

Let us remember that people in their learning interests are as far apart as the poles, and that there are some people who just have never profited by formal study, to any appreciable degree. They have learned about 90 percent of what they have learned through the use of their hands in the work situation. We should think about providing such an outlet for them.

The fifth area is broken down into hobbies, arts and skills, and entertainment, that is, recreation. All right, that is an outline of the program. Remember that to each one of those is devoted many hours, and the whole ends up with the students joining a group of 10 to 15 people headed by a PR officer and an ER officer, some enlisted men with experience and enlisted men without experience, getting around a table at night and planning a program for a given hospital in detail after we have set the over-all framework.

I have given you the five major elements.

The next step is to break the program down into terms of patients--the 3's and 4's and the 1's and 2's--break it down on the patient level.

I said I was going to come back to military education. Col. Jensen has already sounded the theme of what I am going to say. The need for military education in our station and regional hospitals is perfectly obvious. There we are interested in preventing the regression in military skills. A man is training in either a replacement training center or unit training center, and he has to keep up with his unit or it costs the Government much in terms of manpower and money.

In general hospitals we know we have a different problem now. We say the man has been combat wounded and a great percentage of them are going back to civilian life, and, therefore, there is no more place in military life. It has been expressed just like that by some people. That is a little bit hasty. I think we have got to remember we are in the reconditioning business, and merely because a man has rejected military education because of a trauma suffered on the battlefield, I am not sure that we are on the right track by saying, "We won't ever touch it again." You must realize that for many of these people it is an escape mechanism and if we can't correct the escape mechanism, we haven't reconditioned. We must lead up to an acceptance of a concept of things military for these people, and if we eliminate it from our program, we never will be providing it as a service in a hospital.

Now, there is a sequence of events that we can go through to make this gradual return to acceptance of military doctrine. First of all, we recognize, of course, that a period of inaction is necessary, that we have got to leave them alone. Then, we introduce news, orientation. We might try the staff film reports at a certain stage in this development. We have heard of the experiences of some hospitals where the staff film report has been rejected violently by the patients on the ward; then, inadvertently, it was asked for when the patients became ambulatory. There is a certain period of inaction in there that is necessary, but eventually

these men should be able to come around to accepting the concept of military; after you get that far with them, you are ready for the new training films that are being produced every day, of the technical variety; then you are ready in advanced reconditioning to go on with those men who will return to duty with the skills that that you are going to have to train and retrain in them.

Now, the next thing we go into is a concept of reconditioning as a medical service. We try to impress upon them that professional dignity is essential in winning the respect of the medical officer, and we have been much concerned about the "soap-opera" publicity in promotion that is springing up in the field. It is sort of a carnival type of thing that I can't put my finger on, but bands playing, and banners waving, and hawkers trying to sell something like snake medicine. We try to point out to them that if they are author to something such as that, they are not going to elicit the confidence and support of the medical profession because the medical profession spent many years in chasing snake medicine out of the country.

There is another danger in that type of publicity and that is that it gets away from you and the press gets hold of it. It makes a large noise and the press comes in and writes up stories about your hospital which are printed in the paper; the paper comes back to the hospital and the soldier reads about something that isn't actually in the program so he loses all confidence in you and the program. And try and get him back, You have lost the man for reconditioning. In other words, he sees window dressing and when he sees window dressing, having been in the Army for quite a while, his confidence is immediately destroyed.

We discuss a corrective phase of that: how to get and win this medical support. Col. Jensen takes over there and discusses the relations of the medical personnel. In my opinion the future of reconditioning is in balance here.

The next thing is to show what is happening in various hospitals in the way that they are developing their programs. We find some hospitals that are going after the problem this way: They start in with one hour and then try to build up and down from that, so that eventually they are providing a service that can use up the entire time of a man's day, if so prescribed by his medical officer: then we have the other group of hospitals that are taking one or two wards, and trying to build the program up in those one or two wards, making an example of it, then spreading it to the other wards in contrast to the first way mentioned. We don't advocate one over the other very strongly. We try to get it down to a case. Well, what is the situation in your hospital and what have you been doing? Most of the time they have never thought of the problem that way, and it is a contribution to them to develop an analytical approach to their expansion.

Then we go into a long discussion of methods of increasing participation in the program by the patients, how to get support by going up through your chief of reconditioning to the commanding officer and down through your chiefs of service to the ward officer, the effects of policy on the reconditioning program, what influence personnel can have on pass policy and how to go about getting it. We have found there some interesting examples.

For instance, we bring up the Tilton plan, or point plan, where Tilton states there will be so many points of reconditioning credit per week, and that the various activities which a man can do each count so many points. That plan is brought up for discussion, compared and contrasted with some other system.

This brings me down to one point about the pass--the emphasis on holding the pass over the heads of the men. We have some evidence that in some places it is greatly overemphasized, that all participation in the program is based on whether or not a man gets a pass. That is extrinsic motivation. I don't think it is sound in the final analysis. The proof is that we have one case in which the program folded up around the ears of the people who were holding the pass up as the answer to whether or not these men participated. In other words, here is what happened: if you didn't participate, you didn't get a pass. So the men went on what was practically a sitdown strike. Nobody applied for a pass and nobody went in for any activities, which brings up the question of compulsion.

Where should compulsion be in reconditioning and where shouldn't it be? That brings up a rather heated discussion that lasts for some two or three periods. We

usually come out with some pretty good solutions to that.

Now, along toward the end some time is spent on reconditioning activities such as industrial therapy, apprentice training, and we emphasize the precautions which should be observed, the administration of such programs and, finally, to make an exhaustive study of the use of films, film materials, film strips in the program, how to go about building a film course, to take a certain subject and go out and find film materials for them, we point out that the Army has more training films on civilian subjects, and by using film Manual 21-7 we can illustrate that very clearly.

For instance, the Air Force series on weather, all the many series on the use of machinery--shapers, millers, and so forth.

Finally, I want to close this with one statement that is important: That unless these students are convinced in the first two or three days that we are completely sincere in our confidence that reconditioning will work, that it is worthwhile, and that it is good, we don't get the students.

COL. JENSEN: One thing I want to mention now: Please take notes about things that you would like to ask us about or discuss in the discussion period this afternoon.

As these subjects are covered there are certain things that we are missing, either to present now or in our curriculum. We would certainly like to hear from you men about it. You have had many of the grads of this school work on you and probably know some of their glaring deficiencies. We would like to know about them.

We are training personnel for you. That is our job and in the discussion period this afternoon we would like to know your ideas about what you want your personnel training in and along what lines.

I might add that we have been fortunate here in having a sufficient staff so we can usually have one or two men from the department out in the field each month. We have officers in every Service Command except the First now, and the Eighth, studying reconditioning in hospitals.

The next speaker is Lt. Sprague.

LT. SPRAGUE: Col. Jensen and gentlemen, I think that the problem which I face this morning is perhaps even a little bit more difficult than Major Lorenzen's.

In the educational reconditioning program, the instruction for which I am responsible takes 41 hours in your DPI, if you will notice it, those hours on orientation and education.

In the physical reconditioning program, there are 12 hours devoted to that and it is manifestly impossible to do more than give a few very general impressions of the sort of thing that we are trying to pass on to the personnel that you send us for training in these important fields.

The students that you send us are dealing with men who are, for the most part, in the process of returning home from long distances--speaking now geographically and psychologically. They have come a long way in this Army. They have been taken out of their comfortable civilian environments and put into a war--a war that they didn't know very much about. Some of them, if they were asked why they were in the war, might have expressed it by singing that rather cynical little song that some of our classes sing as they pass from one class to the other: "Why are we here" And then theysay, "We are here because we are here, because we are here," and for a whole lot of soldiers in the United States Army, that is the best answer, the most realistic anser, that they can give.

In hospital orientation we have all of the problems of orientation in the Army generally, plus all of the problems that are peculiar to the patient because he is sick, because he is a casualty, because, as far as he personally is concerned, he has suffered a defeat. We might say that one of the things we are trying to do in hospital orientation is to repair the failures of Army orientation generally. It is hard enough to take a man out of his civilian occupation and put him in the Army and to convince that man that he ought to go out and to risk his life and his

security, his safety, in a war. It is more difficult to take a man who has gone into war, risked that security, and lost a limb or his sight or contracted a disease which he feels may be with him for the rest of his life. We are, perhaps, over-trying to do that very difficult job--an almost useless job, we think sometimes--of locking the barn door after the horse has been stolen. Perhaps we ought to consider just a moment why we have orientation in the Army, anyway--not just in hospitals, not just in the Medical Department, but in the Army.

Why do we have it? Why do we think it is important to teach the Infantry soldier why he fights, and the casualty why he fought? It isn't because someone thought it would be a good idea to give someone a background in the philosophy and the ideology of this war just so that he would have for himself a more satisfactory experience in the war. It was a matter, if you please, of stern military necessity. We are losing battles, we are losing personnel. The years that went between the First World War and this one were not years that were particularly good for the preparation of a soldier for combat. We have had some 25 years of thinking that was characterized by isolationism and pacifism. That was not good psychological preparation for military service. And then this war itself, by its very military nature, has been a more difficult psychological experience for many. It has been a longer war, more men have been concerned in this war. We have had to draft more men. We have had more casualties. We have fought in more battle fronts with greater weapons, more terrible weapons, than we did in the first World War, and the need for orientation to that sort of a situation is greater than it has ever been before. It may have been all right for the soldier in the first World War to sing "Pack up your Troubles in your Old Kit Bag," and "I May Not Know What This War is about, but You Bet, By Gosh, I will Soon Find Out"--the sort of spirit of satisfaction with the whole program that pervaded the soldier's mind in that first war doesn't exist today. The American soldier in this war has discovered that you can fight a war and win a military victory, and still lose it. He has discovered that you can fight a war to make the world safe for democracy and that Fascism can come into that world. He has discovered that you can fight a war to end war and have another war in 25 years. He knows those things. He is a bit more cynical than his brother veteran of 25 years ago, and the job that we face in the orientation of the hospitalized soldier, be it a station hospital, a general or convalescent hospital, is, indeed, one to challenge the very best that is in us.

We have a guide of what we shall say and what we shall do in the Army in the field of information and education. It is War Department Pamphlet No. 20-3. I have been rather flattered because some of the students around the school here, particularly in education and reconditioning, call this "Sprague's Bible." I like that. I think I have never had a more thrilling experience in the Army than I had when I first came to this school and was introduced for the first time to this pamphlet, which is our dogma, if we have one, which is our doctrine, if we have one. I have sort of an idea you know, as many Americans have, that this business of orientation had to do with the propagandizing of the American soldier and that what they were trying to do to me was to make a propagandist out of me. I didn't mind being a propagandist but I certainly didn't want to be a propagandist for any ideas in which I didn't personally believe, and the thrilling experience was to read the very first sentence in this book, which I want to read to you gentlemen, because I think perhaps some of you have missed it in its full significance. Here is our fundamental principle in orientation in the United States Army:

"The fundamental principle of American information about the war is that we will speak the truth." Just as simple as that. That is all the Army wanted me as an orientation officer to do, was to speak the truth. And, gentlemen, I think that is a thrilling experience for the students that you send here. Some of them don't know that that is really the job of orientation: to tell other soldiers the truth about this war, about themselves, about their country and about the enemy.

Now, I have given you the first sentence in this book. I wonder if you or any of you who haven't been students here at the school could guess what the very next word is. The first word of the second sentence. You know, of course. It is "but." And then it goes on to show how we must present the truth: with common sense, with skill, with an understanding of problems of military security, and always examining all information that we give to the troops in the light of its effect upon the men.

So we have two jobs to do here, and if you will study our DPI, you will see that

that is the way that our curriculum in orientation is divided. First, we are going to speak the truth, and so we must have subject matter which deals with the facts, which tells our students some of the basic facts which underly the war. And then, because the "but" is there, we have to give the students methods and techniques so that they may present that truth to their patients in such a way that it will have a definite and a satisfactory end.

One word about materials, which, I understand, have already been discussed in your formation last night. The Orientation Branch of the Information Division is charged with the responsibility of providing all orientation materials for the Army. That does not mean that we may not buy the book "And Now to Live Again," and other books that are published by civilian organizations, but the official publications of the Army are given to us, as to other branches, by the Orientation Branch of the I and E Division.

May I point out that the mission of most of the units serviced by the I and E branch is not identical with our mission. For the most part, they are interested in combat orientation. That is to say, to prepare the soldier psychologically for a combat situation or to get a soldier ready psychologically for a military job of some sort in the Zone of the Interior.

It has already been impressed upon us in this conference that perhaps 80 percent or more of our job--and that will change from time to time--is to prepare men for return to civilian life.

I would like to give you this idea: that in the field of orientation we are ahead of the rest of the Army. We are already at grips with the problems that the rest of the Army will have to face at the end of hostilities. But because now we are ahead in our mission in regard to these returning casualties, some of the materials that we receive from the I & E Division must be carefully adapted to our particular use in the light of our different mission, and that is one of the things that we emphasize at the school. We try to teach the students how they can take these combat orientation materials and relate them to the needs and the experiences of the returning soldier who is not going back at all into combat.

One of the things we do at the school is to use our student specialists in the presentation of the content of our program. In the present class, for instance, we have a student probably known to many of you--Cal Tinney, a former radio commentator, who has traveled widely in the East and who has been stationed in the CBI theater. In our DPI, you will note that we have an hour on "Know your Ally, China." It is impossible for a single instructor to be a specialist on China and India and the Balkans and all of these problems, so whenever we have a man in the class who is particularly well prepared because of his experience and his abilities to present subject matter that we need, we make use of that student in our instruction, carefully supervised, of course; carefully briefed, of course, but we use his particular ability. It is one of the advantages of being here at the School for Personnel Services. We have a larger student body from which we can draw the student specialists that we need.

Let us consider now some of the methods of presenting this material. We have a good many formations, as you will note, that deal with the methods that will be, in turn used in your hospitals. We have no definite theory as to one method which must be employed. We might like to have, but we can't possible have.

In our student body this time we have students from debarkation hospitals where the average patients stay four or five days; we have patients from large station hospitals and from tiny station hospitals; we have patients from the cantonment type general hospitals, and we have patients from general hospitals that are located in hotels reconverted, where there are not more than three or four patients in a single room, where there is no public address system. We have students from New Caledonia and from places in the Pacific where their hospital is in a tent or a series of tents and where some of their personnel has to be employed on the farm, which they have to keep in order to have some fresh eggs for the patients.

To present one method or one theory of how orientation should be presented would be ridiculous in the light of our problem, and so we indicate some general rules for the use-the efficient use--of personnel, and try to develop the ability on the part of our students to adapt themselves to their local situations.

We tell them that they must make the best use of their existing personnel and equipment. We try to show them how to do that. We don't waste any time in just moaning about the fact that we are not sending them out back into ideal situations.

I would just like to quarrel the least bit now with the concept that has been presented at this conference: the idea that it is almost impossible for a person who has not had overseas experience to work successfully in the orientation of overseas returnees. We certainly do not discourage the students you send us by giving them that idea. It has not been my experience that it is almost impossible. There are some pitfalls and there are some dangers; some men can certainly mess it up, and do. But we tell these students that they can work successfully with these returnees, even though they haven't been overseas themselves; then we try to point out these dangers and pitfalls and show them how to avoid them. Particularly in orientation our experience has been that this is possible.

After all, it does not follow that the man who is a casualty, partly because he was not entirely and properly oriented, is the world's greatest expert in the field of orientation. You medical men know that you do not always prescribe the type of medicine for an ailment that your patient would prefer. Of course, you may sugar-coat the pill, but you give him the pill. And just because a man does not want to know about the war, we don't feel that we can accept that. We feel we must discover a way to teach him about the war. That is the realistic problem. It is the only way you can feel about it and work for Col. Jensen.

You heard him talk about personnel the other day. And members of the staff in discussing it, decided that Col. Jensen was still fighting the war in the conference, and fighting the battle for the most efficient use of personnel that we have, and for a realistic appraisal of the task. That is what we have to do. That is what we do. We have some instructors who have had extensive overseas experience who have talked to our students about the patient, the psychological effects of combat and about the difficulties which they may face in dealing with overseas returnees, but we don't let these instructors just point out the difficulties. The go on and point out the successful techniques which may be used, and that is a poin for your in-service training.

Then, of course, we do point out to our students that in the field of orientation we are going to make extensive use of the patient personnel. It means that very often the people we train here at the school will be training teachers back in the hospitals. We have a rather elaborate program of how we feel the most efficient use of this patient personnel may be made, which involves several principles.

First, the principle that every man knows some good about something, and that you can use that man to the best advantage if you let him talk in your hospital, in your ward program, about the things that he knows, and the thing which claims his own interest. So we suggest to these students that in organizing their program they schedule individual instructors on the same topic which they, the instructors, have selected, around from ward to ward, instead of following the principle of scheduling the same orientation subject for all of their wards, on the same day at the same hour.

If you are not trying that method in your hospital, I suggest that you do try it. If you want to read more about it, I suggest that you read the part in your Reconditioning Manual here that we are handing out today: "The Why, When, and How of Reconditioning." If you want to talk to me about it, I would be very glad to discuss it with you.

A word more about our personnel: The thing in which I am most deeply interested when I first interview a student, is his attitude toward the war, his conviction about the righteousness of our cause in this war, and his real interest in presenting that cause to others. Certainly, that is something that can't be measured in terms of a degree. I want to tell you about an experience that I had a the school which will back up the comment that was made a little while ago.

I was meeting advisees on the first day of the course and a short little fellow with a heavy beard showing the signs of travel, a private, covered with ribbons, stars, and leaves, and he had good ones, came up in front of my desk and

threw me one of those quick salutes which meant that "Well, I have to do this, but I don't think much of it."

We sat down and we started to talk. I examined his qualifications card. He had left school in the fifth grade. We have a fast moving scholastic program here, and I was a little bit dubious about the possibilities of that man passing our course scholastically, and I started to talk to him about it.

I said, "How did you get into reconditioning, anyway?"

He talked with a very throaty voice and he said: "I will tell you, Lieutenant,

He said, "Over there I was pretty good at talking to these fellows after they went into battle and cheering them up and sometimes I would just slap them on the back and say: 'It's all right. It's O.K. We will be able to do it,' and I thought you know, since I lost my thumb--" his right thumb was gone "--that maybe this is something I could still do. These fellows who have come back from overseas, I can talk to them because I have seen the same things they have seen."

I said, "Yes, Private, I appreciate that, and I think that is just fine. I like your spirit, but I just want to show you what you may be up against. In the scholastic program here at the school you may be in competition with some men who have had some scholastic advantages that you haven't had. Let me show you what I mean," and I reached in my card file and quite at random pulled out one that I couldn't have selected better if I had looked them all through. Here was another student with an A.B., his Master's degree from Columbia, and his doctorate from the University of Chicago, and I ran my finger down across those letters, and I said, "See, here is one of the men who will come and be another student in the course," and he looked at those letters and he said: "What's them?"

I said, "Well, Private, those are degrees which this man has received. It means that he has spent about eleven years in some of the finest institutions of learning in this country and that they have given him the right to put those letters after his name to indicate that he has done that work. Those are degrees."

He said, "Yeah. Yeah. I knowed some of those guys and some of them wasn't worth a damn."

Well, I would like to give the story a happy ending by telling you that he went on to graduate with honors and is now a most efficient orientation officer in the hospital program, but that wouldn't be true. He got into the program by mistake. I think he just went into our motor pool and fell into the processing line, but in hospital orientation I will take a man like that with right attitudes, who is teachable, who wants to learn, and who has a conviction that he is on the winning side in this war, because he is on the right side, and run an orientation program that will be a hummer. I think that that fellow maybe wouldn't appreciate a discussion on the Greater East Asia Co-Prosperity Sphere and the Monroe Doctrine, but I think you could give him the concepts that you would want to get across in that sort of a discussion in simpler terms and make it effective.

We are going to take the personnel that you send us and my plea here is that you send us personnel that is convinced of the righteousness of our cause, and has conviction that they must present it, that that is their job. We try to weed them out. We get some men who have had attitudes. We try to discover those men. We don't run any G-2 but we try to find out and try to see to it that men who do that sort of work turn their effort to other areas than reconditioning work. Sometime they slip by us.

We have free comments and I got a comment at the end of the last class which indicated what sometimes can happen. One student said something like this. He said: "The instructor was persuasive and 20-3 was presented in an excellent manner, and a good case was made as to why we must accept these un-American ideas at the present time." I don't know who he is or where he is. Perhaps he is in your installation right now. But that man in orientation is less valuable to us than the fellow who had deep conviction, perhaps little understanding, and no college degree.

COL. JENSEN: Thank you, Lt. Sprague. Lt. Sprague high-lighted one point that

we have discovered here by a very unique little process. You know the students write back, they know our address, and after all, they graduated from our college, and if they are not succeeding, they write and tell us about it, so we get quite a few letters almost every day. Some of the boys who we have been pretty sure were phoneys, were found out right away by the soldiers. It didn't take them four weeks to wonder about it. I think you have all experienced this. There is nothing that a wounded soldier can figure out as fast as insincerity. He knows it as soon as it walks on the ward. And somebody who is building him up so he can stay in a nice fur lined foxhole himself, he rejects.

So our problem and your problem in this business is a little bit like the problem of graduating a man from a theological seminary. If he just doesn't accept the doctrine, he is going to have a hard time convincing his congregations.

I am going, in the next few minutes, to tell you about the staff study, what it is, and how it is used here at the school.

As you have already been told, our students are divided into teams with an experienced officer -- an officer experienced in reconditioning -- as chief of this team, and the team corresponds to the reconditioning staff in the hospital. One can see the advantages of such an arrangement, for we have many here in the school who haven't had any experience in a hospital -- in fact, they hadn't even seen an Army hospital until they made the trip down to Woodrow Wilson. The staff study is a teaching device. We are making use of the student experience as a basis of evaluation, a basis of evaluation of the program in the hospitals that are represented here at the school. It is also a basis for evaluation of the growth while they are here at school.

Ofttimes, unless we look back, we do not see our own progress or change of thinking, so the staff study is divided into two main parts: the estimate of the situation -- and in this estimate the team discusses the program facilities, organization, all those factors that pertain to reconditioning in the hospitals represented by that team. In this class the teams run about 15 in each, with educational and physical reconditioning officers, educational reconditioning enlisted personnel. After they have discussed these different hospitals, then, they go through this estimate situation that, in effect, is an outline of the factors that have to be considered in working a program, and they decide then their present place in reconditioning. That is, the progress that has been made, just what they are doing. It is a combination, as it were, of several hospitals. It is not any one particular hospital.

Some of you, as I see out here, are former students and you remember that you worked out the staff study alone, you used your hospital if you came from a hospital. If you didn't, you are using Woodrow Wilson.

We find that this new plan has many advantages, for it gives those without any experience a chance to profit from the experience of others. Then, on this contrasting, after they have finished the second part, which is program planning, the individual student can go back and compare the estimate of what he had as against the program that he has planned as an ideal, and see the changes and additions that he has made in his own thinking. It also gives the staff a chance to evaluate him.

Now, it would take entirely too long to go into the staff study in detail. I have given you the main idea, the estimate of the situation. There are four main sections in this estimate: the organization, training facilities, the program in operation, and attitude of officials. Of course, each of those is divided into subdivisions, and goes into the program quite thoroughly.

Now, the meetings or classes are under the supervision of this student officer this chief of reconditioning. Those meetings are held in the evenings. It means a lot of extra work.

Last night the teams were meeting, rooms had been assigned. Faculty members were assigned to act as advisors in these groups. Now, I say advisors. The Chief of Reconditioning has control. He has followed out certain procedures and plans as set down by the schools, but the program is a program of the group.

Now, planning the program: after they have completed the estimate of the situation and it has been reviewed by the faculty, discussed with the team, then they are given the second part of the staff study. Here they draw up plans covering the four major fields I referred to, and their immediate plans upon their return to their hospital or assignment to a hospital, as the case may be. Then the plans that they expect to attain--the program they expect to attain--in three months' time, and then the third, the ideal program, as they see it at the time they are working out this program planning.

This is necessarily a stupendous task. Those of us that worked the staff study individually know that we spent practically every evening of the last three weeks working on it. These people meet two evenings a week, and then they are assigned specific duties in the program planning by the chief of their team, and on the other evenings they prepare that material and bring it back to the group for evaluation.

Last week I sat in on one of these meetings, and one enlisted WAC had prepared the material on the library facilities. That was her specific job. The group discussed that, and I know that from the combined thinking of the 14 who happened to be there in that particular team, that the rewrite which the chief asked might be done would be much better, though it wasn't a bad piece of work originally. It really was quite good. I really believe that the students themselves are sometimes more exacting than you or I when we are on the faculty and working with great numbers of people.

Now, I believe I have outlined to you the reasons of why we have this staff study. The completed staff study done by the groups is typed up and given to each member of the team. In this material they have many things they refer back for they are covering all these phases that you have heard about or will hear about when we are talking about the school.

For instance, under organization, you will see all these different charts, their places, the source material, orientation. They have to develop topics and take one of those topics and develop that, and one of the group in the team will present it in the practice teaching, so that the staff study runs through the entire four weeks, covers all this material. They will have additional notes, and they take notes, and they are given considerable material, as you have noticed over here on the table, we have laid out some material that is given out to the students to take with them to help them in their program.

The staff study then becomes a very valuable reference for them.

Now, I was to tell you about the course in Army instruction practice teaching. It ties in, of course, with the staff study, in the parts of the staff study calling for lesson plans. In the course of orientation, each of the five fields that we have covered has been covered here--elective education, military education, and so forth.

The Army instruction course has been taken from our field manual 21-5, and the T-M's. We have used the RTP put out by Carlisle Barracks, we find that very good, and other service school material in developing it. In this Army instruction course we have each hour lesson planned and mimeographed; we hand this material to the student. We tell him this: that here is one class where we don't want him to be burdened with the problem of taking notes, for we are going to try to give what many of them had in teacher's college: a course in methods in about nine hours. You can imagine how much pressure we put on to cover that, and now we have to put in what we used to call educational psych along with it, so the course is very concentrated; it also outlines the prescribed Army method for lesson planning.

We have letters from them in the field saying that they find these notes and reference material very valuable in setting up their own training courses when they are training instructors at their hospitals.

After he has finished the nine hours of Army instruction, each student has a 30 minute period in which he presents a class. That is divided in these various fields. Part of it is in the staff study. These are the people who are working the staff study, they have had an idea as to what they want to do, and from these assign

ments they conduct this class. The students have a fifteen minute critique in which they point out the strength and weaknesses of that particular presentation so that we feel that our mission in Army instruction is to assist these people--to many of them it is a refresher--but to assist them in doing a better job of instruction, and the selection and training of instructors, which, as we know, with the shortage of personnel, it is going to be necessary to bring many people into our program that are not assigned and not trained at a special school such as we have here at Lexington.

COL. JENSEN: There are two things I want to point out about the staff study. In the estimate of the situation, we find out all the troubles and they vary from a commanding officer who is felt to be uncooperative, to the absence of a hospital practically--at least a hospital as you and I understand it. When one of these boys from New Caledonia starts telling about a series of tents that he has stuck up in the hills some place, or the absence of equipment in Iraq and Iran, we take the problems that this individual feels are very serious, list them as favorable or unfavorable and ask him for a conclusion, ask him to work out how and why they are unfavorable. From the group we find most often, without the instructor saying a word, that there is someone who knows how to solve that problem. They don't have that problem in their hospital. They used to but they don't have it any more, and he tells them how they solved this problem. After they work that out, then they start to plan a program.

This staff study procedure is not a procedure to give the man a program to take home to his commanding officer and say, "Colonel, this is the way reconditioning should be run. I was taught this at the school." We impress upon them that what we are trying to get them to do is to think about the real problems of military education and the solutions to those problems. That is what the whole procedure is about. It would be much better if we could give them an internship in a hospital. We don't have that opportunity here. You will have to give them an internship. I don't know how much medicine I learned before I started an internship. It didn't seem like much to me. I think most of the doctors here will agree with me on that. But I am sure I couldn't have done much with the interneship unless I had had four years training in medical school. That is about the same problem.

On the practice training, we think that the hardest thing to do for a soldier in a hospital is to carry out military education. It often amounts to selling the same old bar of soap, and we are very aware of the fact that the bar of soap has to be sold with a new wrapper on it, and you have got to use different perfume in it, but it still has to be sold. It still has to be military training. It can be done. It can be done very successfully. I have seen it done in many installations successfully, but you can't do it with the same old training manual and the same old training film that the fellow got his fill of during basic training. Yet there is a great deal of information in basic training that no soldier knows enough about and that material can be presented properly and interestingly, so in the nine hours of instruction on this, we attempt to show them how it can be done, by doing a very good job of it ourselves.

Now, for the next period we are going over to the gymnasium and take up physical reconditioning.

AFTERNOON SESSION

COL. JENSEN: The next hour is divided into three groups.

The first speaker is Mr. Pennock, Instructor from Springfield College, Massachusetts. He teaches anatomy, kinesiology, physiology for the reconditioning department here.

MR. PENNOCK: Colonel Jensen, members of the conference, I have placed in your hands this brochure or monograph, which gives an outline of some of the materials which I present in the two courses for which I am responsible: Anatomy and Kinesiology and the physiology of exercise.

My purpose, in the time allotted me, will be to present materials, teaching methods, and visual aides. You also have at your chair an outline of the materials which I use in the two courses of mine and as we go along through my presentation I

will speak of those that you might be able to follow in better manner.

The first of those outlines marked, Basic Outline for Anatomy and Kinesiology you might turn to, as I will begin with that.

In a few models like this and a few others which we have, I attempt first to develop the three planes of the body into which the body is divided--the saggital, the lateral plane and the transverse.. For this purpose, all activity, all exercise all apparatus work, terminology develops from an understanding of these body planes and a movement of the body in line with those planes or in opposition to those planes.

Terminology with respect to anatomy, like superior, inferior, external, internal, exterior, posterior and all are defined with respect to motion in connection with these three planes. That is the first material which we present in one lesson

We have the men for twenty-five hours total in the course in anatomy and kinesiology.

For the second hour, following along in what is somewhat a sequential order fo one session, we present materials on tissues, cells. For some of this presentation the aides used are a projection form of slides, baloptican, from book illustrations and figures, and some of it, where we find inadequate materials, we attempt to make visual on the board through sketching methods.

These are the various fibroid types of tissues which we usually discuss, epithelial, nervous, liquid and so on, tissues. In addition to projecting the fact in that manner, we have some charts which are used to show certain body cells and tissues. Going on from cells, tissues which are a combination of cells and intercellular material, combinations of tissues which help to form organs, and groups of organs for some particular function or purpose, and great body systems like the digestive system for instance, mouth, stomach, intestines, accessory organs, liver, and so forth. A very brief time is given to this phase of the anatomy material. From our point of view, the detailed knowledge of organs, glands, body systems, is not essential.

After presentation of these materials, we next go into more detailed information in conjunction with our teaching of the bony system - - osteology. Some of the aids used here are charts such as these, which, however, show flat conformation of bony structure, and this in my judgment is the best teaching aid for a knowledge of osteology. So, we use the skeleton. It is my point of view also that ther is no necessity for clogging a man's mind with a lot of detailed knowledge in a program of this type, a lot of detailed knowledge with respect to learning all of the raised and depressed markings on bones. We just deal with them from the standpoint of their relationship. The fact that the raised markings as a rule, the point at which muscle attaches, upon which it pulls. And the depressed markings either have a relationship to a tendon groove, blood vessel foramen, or some nerve passageway so that one session only is given to our information in connection with the bony system.

Next we proceed to detailed information in connection with joints - articulations - the moving points between bones, points at which when muscles pull upon bones they move the body in various ways. There are various kinds of joints in the body, and so they are usually spoken of as amphiarthrodia, enarthrodia with no movement and the diarthrodia less freely moving is presented to the men and the movements found in each of those joints. It is also my feeling in a program of this type that the detail in connection with knowledge of all of the names of the bones of the body is unimportant in some respects. In connection with all of those tiny bones of the foot -- small bones of the foot -- and particularly those of the skull The bones of his trunk and of the extremities we do ask the men to know the names o and give more detail in connection with those.

The next in order -- materials in connection with knowledge of musculature, muscles of the body -- are presented in various ways. This is the bulk of the teaching in this course.

Through the use of a skeleton of this type -- so-called muscular skeleton, which shows and has labeled upon it the attachments of the muscles of the body, In the

second outline which you have, the Basic Anatomy and Kinesiology materials, the table shows the muscles which we cover in this course. About 80 some muscles in the body. When you realize there are perhaps 600 and a few muscles, as I gathered from searching, we present about 85 per cent of them, which doubled means about 170. And so, in that connection, these labeled and colored attachments on the bone show the origin point and the insertion point of muscles on the skeleton. It is one of my beliefs that it is not necessary in a program of this type to ask men to memorize in detail the attachments of all of the muscles of the body.

Prior to considering muscles by segments in detail, some basic information must be given in connection with kinesiology. If I might interpret, kinesiology simply means the science of the body motion or the analysis and science of body motion. So that I must get certain principles established in the men's minds -- the question of levers and leverage, multiplication of power, parallelogram of forces, falling bodies. If the speed of a falling limb is no faster than the speed of a falling body, and the limb being the falling body in this case, there is really no particular conditioning or reconditioning. If the speed of a falling body is accellerated, and I accellerate, then I do some conditioning, then I exert some force, expend some energy, press upon blood vessels to increase the circulation, increase the heart circulation and respiration. It is principles of that type which we must firmly embed in the men's minds in order that they understand basically what we mean to imply by kinesiology.

Other principles of body mechanics are the question of support, as to whether there is one point of support for the body, two points of support, three points of support, which change the gravity position -- the balance of the body -- and in that way are muscles exercised. They pull upon the bones, move the body tissues when stimulated or enervated through the brain centers, nerve passageways, and in that way, according to the doseage and other principles are muscles developed and reconditioned. After presenting this material in the first outline which is in your hands, which covers six of our sessions, we then give three weeks to this detailed information in connection with these 85 muscles I have spoken of.

If you will look at the outline you will notice it is in a columnar arrangement, including the location of the muscles, the attachments of the muscles, origin and insertions, the actions of the muscles, and finally the application which we try to make to the exercises which Captain Solomon and his corps of men present on the field and the floor in connection with the work in the swimming pool.

In addition the men, of course, have their texts.

Bowen's text, which we follow very carefully in our kinesiology, William's and many of the reference books you have noted over in the library.

These muscles are arranged in three groups: upper extremity, the trunk muscles and the lower extremity. There is a week given to each group of muscles. They are taken up in a regional or segment order. That is, shoulder girdle -- muscles which move the shoulder girdle -- each muscle in turn. Arm, each muscle in turn. Forearm -- very little detail in the hand. I believe that the detail in connection with exercise for the hand belongs in physiotherapy.

We lay stress on the large groups of muscles which are usually activated and exercised in that program.

Lieutenant Gerlach has kindly consented to act as my subject and will mount right up here and we will show you another method which we use in trying to get across this material.

With a flesh pencil we attempt to show, through sketching, where a great muscle like the trapezius, for instance, has its origin, its points of insertion, and then outline -- it comes from the head and down -- in this fashion. This is, of course, the great trapezius -- an attempt to outline those muscles, particularly that muscle, that great trapezius, as it pulls, sketching origin, insertion points.

In much of this work the class participates. We point to a man and ask him to tell us what the muscle is after we have sketched it, approximately where its point of origin is, where its point of insertion is. Muscles pull. They pull in

their direct action toward the origin. We can fix the other end and move in some respects the insertion toward the origin. And these are some principles of synergestic action, agonists, antogonists, direct reversed action, fixation, the fixator muscles and the fact that although this may be the muscle acting directly, or this particular group may be acting directly, other muscles are stimulated and exercised somewhat. Fixators we call them. Those ideas and principles we must get across to the men. This muscle as you probably know is divided into about four parts and each muscle in turn is outlined after that fashion.

Of course, accompanying these materials we have various testing methods, both in the class room and in the weekly examinations which are given here, and if the men will roll the bed out into position we will show you how we attempt to correlate this work with the teaching of the exercises which men go through, as you saw them this morning in the gymnasium, as you see them down on the field, and as you men who are in charge of hospitals many times have seen them there.

With the group sitting here in class, and with each pair taking their turn, one man being the subject who is going to demonstrate the exercise, the other man aiding in analysis, each exercise in turn is taken up. It shows whether the man understands the exercise. It shows also whether the other man has caught the point in connection with muscular analysis for reconditioning of the body.

Limbs have been moved to a certain position. The man must know what muscles brought him up to that position -- what that movement or those movements, or the movements of those segments are, so that he knows the muscles which are being reconditioned -- so that he not only knows the muscles which are being reconditioned but also why some exercises are <u>not</u> given to a man.

If muscles are held in a fixed position, that is a static type of contraction, and of course, expends energy. The man must be able to analyze whether it is a lengthening, shortening, or static contraction, to know the muscles activated, and the segment.

The members of the class act as critics; they use the critique method in these presentations. It also gives me an opportunity to grade the man, which we do at each of our sessions when we start into the analysis; these analyses follow the presentation of the muscles of these great groups -- upper extremity followed by analysis; lower extremity, followed by analysis; trunk, followed by full body analysis when we have presented all the muscles and the movement of the full body.

Accompanying the anatomy and kinesiology information, is the material on the physiology of the exercise. In this course we attempt to present the reason why we exercise, how we should exercise, how much we should exercise. In other words, to establish principles of dosage, intensity, load principles, maintenance principles, how much exercise the men should do, how much they can stand, the intensity at which they work. This, we point out to the men, is controlled through the cumulative count, as one of the factors.

As I attempted to demonstrate in connection with raising the arm or lowering the arm rapidly, speed is an element entering into dosage, load and intensity, duration, another principle we must get across, the length of time men exercise. These principles, of course, are related to the great body systems, conditioned through physical activities in the reconditioning program.

Through the muscular system, muscular stimulation and exercise of physical activity the digestive system, the respiratory system, the circulatory system, all great body systems, are stimulated, more blood is driven to them, wastes brought away.

As a result of some of these principles, when muscles shorten in contracting they press upon blood vessels. Primarily we think of it from the standpoint of the veins as the arteries have pulsation back of them. In that way, the blood is rushed to the heart more readily; also the lympathic system, a very sluggish and slow stream. In the final analysis in connection with the physiology of exercise materials, we point out to the men the effects of exercise on the body, the effects to the muscular system through enlarging the muscles or so-called hypertrophy; also the other effect if the man lies abed too long, wasting, atrophy, deterioration; and in turn, the benefits to the heart, to the strengthening of the heart muscle, the benefit to the lungs through alveolar tension, and strengthening of the lung structure, the strengthening directly or indirectly all of the great body systems.

Not only do we point out the benefits from activity, but some of the dangers resulting from over activity or failure to control through the principles I have just mentioned, load principles, dosage principle, maintenance principle, and -- failing to control those factors -- the danger there may be to the men. Effort syndrome, so-called, which you may be acquainted with, strain, which we are all quit well acquainted with, if we have had any muscle soreness next morning after heavy activity, and ways in which at least we can better control so that we do not have too much of a strain.

COLONEL JENSEN: I think Mr. Pennock's short discussion here has illustrated better than anything I can say the philosophy that we try to put over to people who come straight from the field into physical reconditioning, namely, that as physical educators, they were locomotive repair men and now they are going to learn how to fix watches. There is a lot of difference between building a football team for competition and building a man back to normal physiology from a sick bed.

We feel that his background in anatomy, kinesiology and physiology is essential to the understanding of that philosophy. We are aware of the fact that the man is not going to be an anatomist, a physiologist, or a muscle analyst, but he is going yo work with the medical officer and under the direction of the medical officer; we hope he understands a little better the terminology the medical officer uses and the concept of recovery, than is generally appreciated in physical education, particularly of the major sports variety. It is my pleasure next to present Major Mac Claire, Director of the Personal Affairs Department, which plays an important part in reconditioning. The Personal Affairs Division, ASF, is placing in your hospitals Personal Affairs Officers. Major Mac Claire explains to us here the function of those officers.

MAJOR MAC CLAIRE: Thank you, Colonel.

Gentlemen, after hearing a bit of the major theraputic measures, I am simply going to present to you a minor aid, otherwise known as a personal affairs program, personal affairs office.

I am talking naturally from the standpoint of the patient in a hospital. I would be the last to admit that it was a minor program insofar as the overall pictur was concerned; I do say advisedly that Personal Affairs is a theraputic aid.

I have very good authority for that -- none other than Colonel Jensen -- who will support me in my contention. We feel and teach in the Personal Affairs program that there are two particular points in the convalescence of an individual where the Personal Affairs officer can function very efficiently. We know that perhaps one of the first requisites of the patient on entry to the hospital is attention to his immediate personal affairs. That is uppermost in his mind. That serves as a sort of clarification of the atmosphere -- the confusion, the mental confusion which the patient will have -- which he does have -- and which prevents you from reaching through to him at the time.

We also teach our Personal Affairs officers that at the time when reconditionin has revived that patient's interest in his future, has satisfied him that his disability can be altered, improved, or entirely removed, he begins then to have a different outlook on life; he can and does raise questions like the three year-old who asks "Why Daddy?" and Daddy sometimes has to have help. In this case Personal Affairs will help us in providing that help by telling us why and how, increasing if you please, his will to recover completely.

Well, where do we come together -- the reconditioning program and Personal Affairs program.

Of course, as I have said, the reconditioning service in this particular attitude or phase is the major service, and we are only a tool or adjunct to that service for a particular purpose, but the reconditioning service on the other hand, can and should use a personal affairs office in the hospital to the fullest extent for the benefit of all direct convalescence. We teach our people that the individua patient, as you well know, must be considered as an individual not a serial number. His disability is peculiar to him; no matter what you and I think or how we classify it, it is still very peculiar to him, it is a hundred percent disability so far as he is concerned, and so are his personal affairs. They may be minor, but they occupy

his attention and if we can, in our phase of the work, take that much off of his mind and leave him free for you, then you can utilize us.

I am speaking purely from the theoretical viewpoint, not from the practical point, because we have a different situation in every different installation. It is a subject very close to my heart to realize that we do not accomplish the full purport of our training at this department in this School for Personal Affairs Officers.

As a practical matter there are probably just as many extensions of the program as there are general hospitals. I would hesitate to say that all the personal affairs offices were conducted exactly along the same lines. Perhaps that is as it should be. Circumstances vary -- lack of personnel, the attitude of the individual personal affairs officer, the relationships of the various agencies, all govern the working out of the program.

I don't know whether you have received or seen this program from Cushing General Hospital. That probably is one of the high points in working out a personal affairs program as it can be worked out. It shows complete liaison. We don't always have that, as you probably know. We can get it and we can get it largely by your help as well as our own.

Remember that the Personal Affairs Program, as such, is less than a year old. The circular which first brought it into being in the Army Services Forces was dated 7th of February -- Army Air Forces have had it prior to that time. Without going into a great deal of detail, which I know some of you are familiar with at your own installations, or into the overall picture, I simply want to reiterate that the Personal Affairs Program can and should be a therapatic aid, and we certainly solicit your cooperation with our program.

COLONEL JENSEN: I am sure you are all aware of the great contribution these people can make to our field. You must remember the time they are here -- they are carefully selected before they come -- and in the time they are here we take up such things as government insurance, the GI bill of rights; all the things that have to do with a man's personal affairs in the Army are taken up and these people who graduate from Personal Affairs School and come into your hospital are qualified to do that type of counselling work for the men. They are the GI's lawyer and are on call for him.

Another important phase of our work is Special Service. We heard some very excellent discussions of music yesterday afternoon and last night. We have talked a little bit about soldier shows in hospitals, we have talked a little bit about recreational programs. Major Gwynn gave us a good review on that yesterday. It is now with great pleasure that I introduce Major Barry O'Daniels, the director of the Athletic and Recreation Course here, the course that trains the Special Service Officers.

MAJOR O'DANIELS: Gentlemen, we have a great conviction about the AR program. We believe in its purpose. We believe a tremendous job can be done by the right kind of an A & R officer in a hospital.

Let's go back to the history of Special Services when it was first inaugurated, known as Morale Services at that time. The thing happened that probably happened with reconditioning.

What occurred? We didn't always have the right type of man to do the job. And why? Because a directive went out saying there shall be a special services officer appointed.

It was new, it was strange, it was a time when plans and training were most important. What did the commanding officer do for such a wonderful job? What did he do?

He said, "I can't let <u>him</u> go, he is too important. I can't let that man go; I can't spare him. I can't spare him, he is a very important man. Wait a minute, that "jerk" over there. (That is exactly what happened) We will make him the special services officer." The man who had the biggest challenge, the greatest job in the Army, to my way of thinking, was selected that way. We have men of great conviction, men of great belief in the job to be done. We are proud of the record of the men in the special service field.

Now, in relation to the hospitals. It has been my observation, having worked in hospitals with the special services program, that many an individual handicapped by being everything else but the special services officer; he didn't have the time to do the job, and yet believe me, a good special service officer in a hospital, if he devotes his entire time to do nothing more than special service, has a 24-hour a day job. Whose responsibility is that? The commanding officer of the hospital.

I recall, gentlemen, believe me, over a year ago in a hospital that I shan't mention, just newly opened, boys had just come in from Africa, they were in bad shape. They were bitter, they were cynical, they were fed up. You know how overseas men feel about these things. They had a special service officer there, so-called. What did he do? They had a moving picture projection machine but no films were being shown. They said, "Why can't we see some pictures? We haven't seen a picture for ages." "All right, I will fix it up." the men were wheeled in there. Some of them came in on crutches. Do you know what he showed them? -- Training films. Why? Because he had no imagination. He didn't believe in the job he was doing. Do you know what the boys did? They took their crutches and threw them through the window. They broke up the furniture and the morale of the whole gang went down because one man didn't think.

One of the things we teach our special services officers, and we really believe in it very thoroughly, is this: I don't care if you have a Doctor's degree, if you have a Master's degree, if you are one of the most intelligent men in the Army, if you haven't got something down here (indicating his heart) don't try.

What you have up here (indicating his head) doesn't mean a thing. Because the men who are doing the job in the hospitals are men who have a deep conviction, a man who might have a little emotional response to a train load of men who are arriving crippled. It is not an impersonal thing to them.

It is a very personal thing. Those are the men who are doing the job. We can only give them so much. They put it down in notebooks. They hear us lecture on the platform. We give them the reference material. We try to tell them to do the job, but if their imagination is limited only to those things, they will fail. Because the individual who does that job must have what? -- imagination and belief.

Imagination! That is all you need, gentlemen. In this school here we have an espirit; we and our department believe in our job, but we know what is done in the field and that sometimes there is an A & R officer who looks with disparagement on another department.

Here, we make facetious remarks about other departments. It is all in fun. The A & R will call the I & E "those broken down school teachers up in the Ivory Tower". They call us "muscles and make-up". They call the reconditioning department "those bedpan athletes". They call the personal affairs department "those broken-down wet nurses".

It is all in fun. It is understandable -- the human equation -- because the mere fact that we have put a uniform on us doesn't make us any different. We are still the same person. The point is that there is a job to be done: each one of us, all departments, have the same objective: the morale and the welfare of an individual -- and I must say this with all sincerity -- that I know of no other department in the school that has a greater challenge, a greater opportunity to do good than this one -- the one you are in right now -- the job you are in -- That, to me, is a tremendous field and a tremendous challenge.

Again, I refer to the person with the PhD, the person with the master's degree, that erudite individual -- so brilliant. What good is it, if he can't sell it to the individual? Where does the pay-off come? Books? Background? Degrees? No, there is something personal in the job to be done. By the very same token, the individual who may have been a failure in the school academically, who may have flunked both tests and come up before the Board because he was academically down in the lowest group -- I would take him on my staff tomorrow, because right down here in his heart he believes in the thing to be done.

We find in hospitals, it has been my experience, gentlemen, that the A & R officer lacks cooperation. Are the Red Cross, the reconditioning officer, the other units, the other groups, like that? Each pulling away from each other like spokes on a wheel, the wrong way. No reason for it. We try to impress upon them, above

everything else, that they are all there for one job. What happens? We find the fellow who says, "Why, I can't go any place here. The T/O is such that I will be a second lieutenant for the next three years." Those are the fascists within our own ranks. They are so concerned with their own petty selves that they shove the program off like that. We talk about the lack of personnel. It will always be that way in the Army, but how many men can get a group of people to do the job and inspire them so with the job to be done that those kids will get out there and knock themselves out for you.

I also want to tell you that from the performer's viewpoint there is nothing more thrilling in my experience than to work before a bunch of boys in the hospital. How they really enjoy it — their response.

Do you know what I have actually seen happen, working in the psychoneurotic wards? Men who before gave nothing, just were completely negative to everything, would react to entertainment. They wanted to be a part of it. They would get up and say, "When are you coming back again?" One was a fellow who hadn't spoken to anybody or done anything for sixteen weeks: a man had a pack of cards and did some tricks and said "Will you hold this card". For the first time the patient showed some interest so the doctor asked the entertainer to come back and work with him again. Before the evening was over he was doing card tricks and from then on he was progressing and getting well. We know it is not a cureall; we don't say that, but we have a great deal to offer to you, gentlemen. But is it worth offering to someone who won't receive it, someone who kicks it out the door and says, "I am not interested."

In closing, I want to talk about the future of this thing. The challenge is going to go not for today but for tomorrow and the next day. And how many individuals do this? —

I have done it and found myself lacking so many times. At the end of a week, take five minutes and say to yourself, "What have I done during this one week to help those fellows? What constructive thing have I done beyond the regular line of duty to put over my idea? Every week you do that. It is surprising what will happen at the end of a year's time. But the most important thing is the direction of the thinking of the individual in the hospital. Give him a well body. Let him play, let him have sports and games. Let him have shows, let him have the things he wants, but most of all appeal to his mind, his intellect, make him want to do things because he is the one that leaves there and goes back to civilian life.

Multiply him by the hundreds of thousands and his future has got a lot to do with the future of this country and I am deeply concerned about the future of this country. There is our challenge. There is our opportunity.

The next formation is in Washington 25 and we need to go over there rather promptly.

At this point the conference attended a discussion class on industrial therapy conducted by Major Lorenzen.

COL. JENSEN: If we can relax for a minute, I want to have discussion from now until about a quarter to four on what you have seen, questions you want to bring up, then we will have some coffee, then we will have two short talks, then we will have more discussion, if you wish, on the school.

This period we have changed our schedule so Colonel Thorndike could be with us during this discussion period. Colonel Thorndike.

COL. THORNDIKE: Can I duscuss —

COL. JENSEN: Go right ahead.

COL. THORNDIKE: I think something must be said concerning the next two courses and their enrollment in this school — that is physical reconditioning and educational reconditioning. What is the anticipated enrollment of the class that starts on the 24th of January? What is the capacity of those classes?

COL. JENSEN: Capacity is 150 in educational reconditioning and a hundred in physical reconditioning. It can go over that sum — each class.

COL. THORNDIKE: The enrollment is what at this time?

COL. JENSEN: The enrollment in educational reconditioning in this present class is 149. It includes forty WACS. And the enrollment in physical reconditioning is 24, for a capacity of 100.

COL. THORNDIKE: Now, I think it is important to say something on in-service training in establishing it in your own installations and in your own service command.

I think that when any inspector comes out to look at your program as he will from time to time, that as Major Cruze said, he will expect to see an in-service training program.

The other discussion I think will pertain to the lecture we just listened to.

I would like to have Colonel Barton say a few words concerning the aspects of industrial therapy as interpreted in occupational therapy and educational reconditioning, as the Surgeon General desires it.

COL. BARTON: There are five points at issue which I would like to take for the next to the last hour. A bit of history might briefly clarify some points.

Everyone approached the Birmingham General Hospital plan with the gravest of doubts as to its wisdom. The inital rulings within the Service Command were against it. The Judge Advocate General, on appeal, approved the outline and gave certain restrictions. A policy has been formulated which in general is favorable with certain precautions.

However, the Surgeon General personally disfavors the pay incentive in industrial therapy, so that must certainly be taken into consideration.

The use of the term industrial therapy for this process is to my way of thinking probably not proper.

Industrial therapy ought to be reserved for those truly therapeutic situations which the doctor prescribes for a given situation. That is, a man has a weakness of an extremity, he needs to develop motion and stronth, the patient has that interpreted to him by the physician, and he is placed on an industrial assignment which is therefore therapeutic and beneficial. In the case of a neuropsychiatric patient, a broader interpretation of the therapeutic situation is possible.

However, the loose use of the word therapy I believe is dangerous. Major O'Daniels the hour before told you of the therapeutic benefit of the man who participated in the card tricks. The same might be said of the person who gains benefit from the painting of a picture in an art class, The same might be said of the person who when he played the piano at once became improved. Those situations are on the fringe of therapy. No one will deny that they do have a benefit.

I didn't hear any prescription basis for this type of activity being used. The third point I would like to make:

The statement was made that at the outset there was interference with the medical treatment and doctors objected to it.

Through adjustment, the doctors learned to get used to it. Something to that effect. I would say that the emphasis should be the other way around: that hospitals exist for the treatment of the medical and surgical needs of the patient, and that most certainly that should be primary, and any interference with that is undesirable and that rather the schedule of work activities should be made so that it does not interfere with the primary medical and surgical treatment.

The fourth point: There is a great danger, and I am sure Major Lorenzen was highlighting this in his talk — my comments only serve to single it out — [illegible] it is unfair to give preferential treatment to an industry, and it is unfair to give preferential treatment to one hospital. Those of you who have to compete by arranging elective courses in Chickasha, Oklahoma with the Birmingham General Hospital in Van Nuys now that Collier and Coronet magazine proclaim the pay incentive to the world, know of which I speak.

That creates an unfair and most disturbing morale factor elsewhere. It is unfair that Northrup Company operates to secure tax-free facilities, when Douglas Aircraft, which may be adjacent, may not enjoy the same privileges of an industrial market.

The fifth point is much more serious — the latter point can easily be overcome -- the fifth point: Civilian supervisors of industry had access to medical records.

I believe that is contrary to Army policy, and it is certainly unethical medical procedure.

COL. JENSEN: Colonel Thorndike?

COL. THORNDIKE: May I add to that a little? It was mentioned that the Bell Bomber had a similar scheme at Lawson General. The two schemes or therapeutic agents are as different as night from day. Bell Bomber has this project on at off-duty hour only in the evening, where they send their own shop foreman and instructors on a voluntary basis. Those instructors are very glad to come and come without pay.

Am I not right, Captain Blaine?

CAPT. BLAINE: That is right.

COL. THORNDIKE: How many nights a week do they perform this function?

CAPTAIN BLAINE: That is available three nights a week.

COL. THORNDIKE: Three nights a week.

MAJOR BRISCOE: May I ask a question. Did I understand Colonel Barton to say that the civilian employees have access to the medical records. I wasn't sure about that.

COL. JENSEN: That was Colonel Barton's interpretation of it.

MAJOR BRISCOE: I don't believe they do, Colonel.

COL. JENSEN: May I take up several of these things, since I am on my feet here, and clarify them for you a little bit.

Major Lorenzen's statement was that the conflict with the medical officers was solved by adjustment of scheduling, not by adjustment of the doctor.

No. 1. No. 2: The problem of preferential treatment to an industry, whether a man that is in a hospital at Van Nuys, California, should have the opportunity to take advantage of what Van Nuys has to offer, if his brother who is in the hospital at Chickasha Oklahoma, doesn't have those advantages, brings up a very deep social problem.

If we can only treat in one hospital a man as well as we can treat the man located in the poorest facility let's invite Joe in — that is the way he runs this country.

A capitalistic democracy is based on the fact that men can take advantage of situations they find themselves in to use them for their welfare in society.

No. 3, the problem of free labor; it seems to me this is well answered by the pay. I don't see how men are going to make parts for industry unless

they are paid to make them. Certainly they are being proselyted and put upon seriously if they do. What industrialist would dare have a wounded soldier make things for his plant without paying him for it. That comes right back.

I don't think, unless we get around to a pay deal, that we can consider any of this. The matter of the clinical record is misinterpretation. The supervisor, as I understand it, has been informed by the medical officer of the man's handicap, and extent.

One other thing: Medical records in the Army are not confidential information.

MAJOR PATRICK: Except through authorized agencies, I believe, Colonel. In the authorized agency it is through the Red Cross.

COL. JENSEN: It is the registrar,

MAJOR PATRICK: And the registrar of the hospital. I believe I am right on that.

COL. JENSEN: There is a difference. I got in on this thing one time myself and got it explained to me by a letter from Washington about it from the Judge Advocate General's department; a civilian hospital record is. A military record is not.

(Discussion off the record.)

COL. JENSEN: I think this is very good, that we have had this discussion. Colonel Barton, do you want to challenge me on anything I have said here?

COL. BARTON: No, sir.

COL. THORNDIKE: The important thing is what Colonel Barton said about the Surgeon General's desire.

COL. JENSEN: I think that should certainly be kept in mind, but I think it is well that we have had this discussion and I think you can readily understand why we put this in our curriculum.

After all, Collier's has wide distribution, and we can't hide this business; we can't ignore it. It is going to be with us, and we try to give your students, while they are here, a picture as accurately as we can of the truth of the situation there.

COL. THORNDIKE: I would suggest that probably another visit might change the information given in the lecture a little because they have changed the program in the last six weeks.

MAJOR PATRICK: That is right, sir. It is a fairly well balanced program. It is true that still the doctors that happen to be in charge of those patients will permit them to spend two hours or maybe three -- only 70 patients were participating in the shop activities at my last visit to Birmingham General Hospital -- less than 9% of the patient census.

COL. JENSEN: I think the publicity angle is an unfortunate proposition in many respects. I think we have to be very careful to divide the publicity away from the program. Whether the program is good or bad it isn't going to be determined by whether it has good or bad publicity. If we are going to make our decision on the program on that basis we in this room are all running a bad program, our publicity hasn't been good in the past week, the only one I am talking about.

Now, anything more on this phase of the program?

COL. STINE: I would like to ask a question.

Did I understand you correctly to say it was legal for a man in the Army to hold this job -- I mean that it has been legalized completely now. To hold

two jobs. That is to be in the Army and to be in a company?

MAJOR PATRICK: That has always been possible. It has always been possible for a man off duty to earn money — in enlisted personnel. The officers I don't think have a chance at it.

COL. STIKE: Isn't it a fact that an enlisted man can make money up to his base pay and no more?

COL. JENSEN: No, I don't think there has ever been a ceiling set on that.

COL. THORNDIKE: We obtained an opinion regarding the pay from the Legal Division to our office. They checked the Judge Advocate General and as far as the actual pay in this particular situation goes, it is legal.

However, I think that we all agree that it raises other problems immediately.

COL. JENSEN: I don't know whether most of you are aware of this or not but it has always been legal and is still legal for you to practice medicine if the community in which you are serving requires your practice and if you can carry on the practice without diverting your time away from your military duties, and you can collect fees for it.

It is a very common practice in many parts of the United States in peace time years such as along the Mexican Border where there were no other practictioners available in your community. That in our own profession has been established.

CAPT. LICHT: I should like to question the incentive as gathered by the interviewer where he says 50 per cent of the men are willing to do it as a diversion.

The American Optical Company about six months ago installed a complete set of equipment for the grinding of lenses and the making of eye glasses with free instructors.

The men received no pay for it at all but they were able to make, within an hour and a half, a set of sun glasses which retailed at $3.00.

The average turn-out per day was less than one so the whole project was abandoned and I think that the pay incentive is so great that the desire of the men to work three hours a day would interfere seriously with the overall reconditioning program of education, and so forth, and conceivably give a man a reason to want to be hospitalized a little bit longer and make $110 a month while in the hospital as a private.

I think we must bear in mind this money incentive as a possible deterrent to the whole idea of the program.

MAJOR PATRICK: May I say one thing. I have been in this program and trying to catch the spirit and trying to understand what the doctors are trying to do. I am thoroughly convinced that it is against the medical program for a number of reasons that any one of you could name, but in these very elaborate programs that are being developed now and coming out in 419, and the training program, we are likely to lose sight of the fact that some of the best — call it orientation or educational information — can come from the medical personnel.

I look upon myself as an assistant in this program to help carry out that which is the fundamental philosophy of bringing these boys back, and I suspect that Colonel Barton will have to admit that the concept of therapy has been enlarged to the extent that we say that an activity of keeping a man busy, may be helpful to him in recovery, and I doubt very seriously if we can split hairs on just where the ordinary concept of medical care stops and where the activity such as playing a piano or such as learning some new idea about the current world affairs — where one stops and the other starts — so insofar as it is a medical program and insofar as we are conceiving of these activities as being something to keep this man busy in order that he may be reconstructed from a total personality point of view, while his specific injury or specific disease is being cured with the usual medical treatment, that we have got to keep in

mind that the medical people can do a lot in taking interest in the kind of intellectual activity, and that is the thing that I have argued for ever since I have been in the program, and I shall continue to argue for it.

The few hospitals where the program has become unbalanced, is where the medical directors of the program have not seen to it that every activity that was prescribed was not emanating from the doctor who had watched that patient and the doctor who had given thought to the kinds of thing that would be useful to this man from a total reconstruction point of view and that is where I argue more with the medical group: that you ought to, while you are treating him for this specific injury, begin to size him up. You are better trained than anybody else to see what will be useful to him from a total citizenship point of view, immediately upon his return to the Army to duty, or upon his return to civilian life, and I can't leave this conference without laying a charge back to the people with whom I have enjoyed a very happy association.

This is a medical program and the way to keep it that way is for the medical officers to take enough interest to try to help plan and guide in the education and occupational therapy and the physical activities that are to be carried out.

COL. JENSEN: I think, Major Patrick's remarks are very appropriate, and I also think that it will be concurred in by all the doctors here — I thought I might mention to you who are not members of the medical profession, that it is dangerous business to get caught in the mass of what we call therapy, because if you went to the faculty of a medical school you would find that a great deal of their time is spent in very acrimonious debate among themselves as to what is therapy. There is the man in the Staff who only transfuses the patient when it is life or death, and there is the man on the Staff who transfuses the patient when the hemoglobin is below 60% and they both call it good therapy and one considers the other a very radical practitioner, and a dangerous man.

We all know this in the profession. I am reminded oftentimes in this work — and sometimes when I think that the struggle is pretty severe — of the problems that Semmelweis once had with the concept of therapy, and that Oliver Wendell Holmes, Sr. had with the concept of therapy once.

And I think that we in the profession have to be very careful about being dogmatic about therapy and I think we have to keep in mind the survey of what the soldier thinks.

MAJOR LORENZEN: Colonel, you have spoken for your profession. I would like to say a few words about my own. I think we ought to take a lesson from the hostory of public education over the last thirty years. Most of us in this room are conditioned by a formal type of training and for the large portion of American's it has been a miserable failure.

Shortly before I was brought into the service in March of 42 I was running a highschool. I was losing students at a remarkable rate, because for the first time in their lives they could go out and earn while they learned, and I am frank to say that they learned a lot more in a lot shorter time when they went to industry than I provided for them within the walls of my high school, and I had a very progressive and a well-rounded program. Let's not make the same mistake in reconditioning!

Let's not try to think of all people as being capable of being educated by this old formal doctrine that has been so sterile for so many years. Let's look at educational reconditioning as the things that men wanted to do, primarily economic security. That must come into the picture or we fail.

CAPT. BLAINE: We have been hitting around like trying to find the keyhole on a dark night. We know it is somewhere along the building, and approach to any problem that you are going to solve properly is a systematic approach.

At the present time is there anybody that can tell me the overall philosophy of reconditioning that is going to hold as true a year from today as it is

today? If they do that is the answer we are searching for. Now what is absolutely necessary in reconditioning is a set of evaluative criteria. We don't have those!

In going from hospital to hospital and trying to evaluate the effectiveness of the reconditioning program at that hospital we have no standard, no yardstick upon which we can stand and say, "This is good" or "This isn't good". We take a generalized impression. "Well, it looks pretty good," and that is about the status at which reconditioning stands today.

So, the positive need of reconditioning is a definite stated philosophy of reconditioning, a definite stated philosophy of the objectives of reconditioning, immediate and ultimate. A definite method means and set of evaluative criteria upon which we can judge reconditioning, and that shall include all parts of reconditioning -- the philosphy itself and all of the subdivision of that, the program, the staff, the facilities, and all phases of reconditioning that pertain to the function of the entire organization and the immediate and ultimate results.

Now, I know of no real definite sets. The association for the evaluation of criteria of secondary schools has formulated such a set of evaluative criteria.

I think we can learn much from education, as education can learn from industry, and for reconditioning then to set down just what it hopes to be and what it hopes to achieve and actually hopes to ultimately do.

We have a letter sent out to each hospital in our command asking them to set down data to prove the value of reconditioning. I am very sorry to say that not one hospital could present incontrovertible proof that reconditioning was worth while on any series of cases, and if there is such incontrovertible proof the only one of which I really know is a study made by Erickson at Jefferson Barracks on virus pneumonia if we can develop a set of criteria and prove that we are right statistically, then we have achieved one of the real needs in reconditioning.

CAPT. THAYER: In regard to the question of earning while learning, it might be well to remember that War Department Circular 291 expressly prohibits participation by any music personnel in any activity off the post, any civilian activity for pay which may in any way be construed as being in competition with union musicians. It might be well to look up that Circular 291 when that question may come up in regard to any musicians or bands which may be assigned to us.

COL. JENSEN: Shades of Caesar Petrillo.

Colonel Thorndike, do you have an answer for Captain Thayer?

COL. THORNDIKE: No, I haven't. I know that our policy follows The Surgeon General's desires, that the Birmingham plan is not The Surgeon General's reconditioning program. I do think there are other phases relative to employment like in the Birmingham plan, and that is the problem of accident or injury in line of duty. We have no memorandum of the Judge Advocate here and it seems to me we have heard all that is necessary on this subject and I think we had better close that subject to further discussion.

COL. JENSEN: Are there any other matters that the group would like to take up with Colonel Thorndike at this time?

(No response)

COL. JENSEN: Then shall we adjourn for some coffee upstairs?

(Recess taken.)

COL. JENSEN: At this time I would like to present Capt. Ganser, an economist in civilian life, and our reconditioning man on funds, directives, and allied subjects.

CAPT. GAMSER: Gentlemen, in the past few days, you have evinced an interest in supplies, equipment, funds, and your students, the people from your installations that you have sent here, have certainly plied us with questions concerning the tools that they would have at their disposal in the program, the official doctrine that they would receive from Washington, so that they could carry on their program and make sure it was in keeping with the dogma.

The initial directives on reconditioning came out periodically at intervals since the publication of an Adjutant General memorandum W-43 in 1943, and at first it was quite easy to keep up with them. We had that one and a year later Surgeon General's Circular letter 168, and a few months later another memorandum, and finally ASF Circular 73.

However, since then, Washington has become more prolific, and h ve made it necessary for us to catalog the many directives in this digest which you have before you.

We found that the student not only had to have a knowledge of the basic directives dealing directly with the reconditioning program, but also those of related fields, those governing the operation of other agencies which contribute in helping us perform the reconditioning mission.

They had to know about the Army's redistribution system, the evaluation system, a system of hospitalization, so that they would have the necessary background information in the program.

We usually start off our first class in reconditioning to give the students an awareness of the necessity of keeping up with the directives and making sure that their sergeant major at their installation keeps this newest professional service in mind in making his distribution of official documents, by asking them a simple question of fact that has recently come out in some circular just prior to their coming to school to see if they have been keeping up with the directives as they come out, ASF and War Department and Service Command directives, and for this particular class I asked them the question, and it most likely is of interest to you because it deals with convalescent hospitals; whether or not they were preparing a program for the WACs who would be sent to convalescent hospitals. I wanted to know how many in the class from convalescent hospitals were preparing a program for such military personnel, and several raised their hands. Then I asked: did Washington contemplate a program for WACs and they said yes, we have some. They said, "Yes, we have some. We are going to get some more." Then we pointed out that on page w of the digest of directives ASF Circular 37, it is cataloged, which says at the present time no program for female military personnel is contemplated in convalescent hospitals and that no more female military personnel will be transferred to convalescent hospital. That may be changed in the future, but at the present time that is the position of the Army Service Forces. I hope they keep up with directives as they come out.

On the problem of supply, they are anxious to know about the tools that have been put at their disposal to carry out the job and we start with the appendix to Surgeon General's Circular Letter 168, which at the beginning, mentioned a few sources of reconditioning equipment facilities and authorized the construction of gymnasia and go on from there to discuss the more recent directives -- our Med 10-23 and 10-25, table of allowances, 8-5, which we recently received, and provision has now been made for us to receive certain items of issue that are available to advanced reconditioning sections through table of allowances 8-5, and the students will not only have a chance to see them here, but to use them in their teaching -- their practice teaching sessions which were mentioned this morning, and in that way be able to go back to the hospital with some idea of the items available to them.

I am sure in the next class we will have a discussion of the tentative table of allowances for convalescent hospitals since we have been able to secure some copies at this conference and that the students working their staff studies on the convalescent hospital program will be able to employ that list of equipment available so that they could set their program up knowing in advance the official sources of equipment available to them. However, I believe even as valuable as those official directives, which are pointed out we spend in discussing programs in operation, because there they learn -- and we stress -- the improvisations of various installations in other service commands than their own which may be successfully employed in

their hospital. People have, during the period when reconditioning material was scarce, learned to manufacture their own, beg, borrow, or steal, and find outside civilian agencies which were able to supply them with facilities. Those may still be available to other installations who do not know of them at present and from the discussions of the students of the programs in operation they have been able to learn what the other man has been able to accomplish. The same is true in our discussion of outside facilities and their use in the reconditioning program.

The State Universities, the schools in the vicinity, other educational institutions, and other kinds of agencies have offered their services to facilitate our program, and in the discussion of programs in operation and in perusal of the staff studies that come in, we learn of the studies employed by outside agencies and give that knowledge as well as that obtained in equipment lists to other students so that they may employ them as well.

On the matter of funds, several questions have been raised during the conference and questions are also raised by our students on the very same points. We start off with a very basic discussion in our hours dealing with non-appropriated funds by reviewing the principles concerning hospital funds as outlined in Army Regulation 210-50, particularly paragraphs 10 and 13, dealing particularly with hospital funds and discuss the limitations in the amount of funds they are allowed per authorized bed as outlined in several recent War Department circulars and how many go from the subsistence account into the post-hospital fund and the function of the central hospital fund in assisting those hospitals that are not financially in as good position as others and for the students' benefit -- refresher for some, and to those new to the whole program and the whole hospital situation the discussion of the channels in the hospitals to which they must go to make their needs for funds known to the custodian and other responsible officials.

We feel if we can give them these official directives, make them aware that more ought to come -- we have had two in the past two weeks -- 415 and 419, both dealing directly with reconditioning. Four and five new numbers and names and tables of allowances have been mentioned in this conference which have yet to appear in these official circulars. When they know they should be on the look out for them, they will also be on the look out for outside facilities to aid them, will be aware of the fact that improvising many times will do the job instead of waiting until it does come to them and have had ample experience in the staff study in planning a program, then, knowing what their program will be, being able to contemplate their requirements for the future in the way of tools and equipment to carry on the program, and knowing that there are certain funds available, they will be able to help you plan in each hospital the program you wish to install.

Because of the scarcity of trained personnel, we treat enlisted WACS man and officer alike to this extent: that we hope that each will go away from here able to contribute to the planning phase in the hospital.

COL. JENSEN: Are there any questions along this line right now while we have Capt. Ganser here on his feet?

I might say that on this matter of funds, and so forth, we requested permission from Col. Thorndike to send Capt. Ganser in to the Surgeon General's office to check with the authorities there that knew the picture, and he did go into Washington and has, I believe, a fairly recent accurate picture of the fund situation.

I just want to outline in a few words the instruction that is given here to both physical reconditioning and educational reconditioning personnel in what we term medical orientation. There are two medical officers here. Both of us are surgeons, both of us are diplomats in the American border surgery. We divide the field between us to cover this material. The first four hours of instruction is devoted to an explanation of the function of the medical department. The first two hours to the setup in the medical department, its organization and administration in United States, and a little bit about how theaters work.

We do this so that everyone in reconditioning will understand that the hospital in a service command is under the control of the Commanding General

in that Service Command, so that they will understand the proper command lines that exist between the Surgeon General, the Commanding General, ASF, the Commanding General of the Service Command, and the Commanding Officer of a hospital. We think this fundamental information is necessary.

We also try to explain how a hospital works, the relationship of the professional staff to its commanding officer of the hospital, the interrelationship between the various professional groups in the hospital, and the relationship of that hospital to a post, camp, or station on which it may be located.

You have two situations there: the ASF Regional Hospital, the Station Hospital, or the General Hospital located on posts.

Then, the next two hours are devoted to an explanation of the plan for the evacuation of sick and wounded from the battlefields around the world to the zone of the interior. And an explanation of the organization and responsibilities of the professional setup in this over-all plan.

These four hours we feel are necessary in order to prepare the reconditioning personnel, No. 1, to explain to the patients the many misconceptions that patients have about how the medical department operates. Why have I been in 17 different hospitals? We think reconditioning personnel should be able to explain to the patients why this all happens. We also think reconditioning personnel should understand the enormous complexity of the medical department and its tremendous mission so that when he meets or she meets minor frustrations, delays, the program doesn't roll quite as fast as it might, they don't develop what might be called intergroup hostility, the feeling that they are misunderstood, pushed aside, the understanding that it takes time, effort, and understanding to integrate a relatively new program in a tremendous organization already faced with a complex and difficult task.

The second nine hours, or the second block of instruction is nine hours. During this nine hours, we attempt to elucidate the nature of mental illness. The greater proportion — 7 hours — of this elucidation is devoted to the explanation of psychoneurosis. We start out with the fundamental concepts of mental illness, gradually build up to the concepts of character formation and acquaint our students with the term "super-ego, ego, and Id," for example, and get them to understand gradually how a character is formed and how a character breaks under stress.

We attempt to explain the attitudes in existence in soldiers on the basis that there are often symptoms of mental illness. We try our level best to put over the concept of mental illness rather than the concept of goldbrick, no good, nut ward, and so forth. We feel that men must understand that illness occurs in the mind in practically all human beings at times, that we all become maladjusted at times, that we all develop unreasonable attitudes at times, and these attitudes must be understood as symptoms of a man's ill health — mental ill health — and that most of us get well by ourselves, adjust again, but that this disease, mental ill health, is a recoverable business, it is as concrete as a broken leg, and it is as real to the man that suffers from it as decapitation. If we can drive home just that concept, we feel that we have accomplished a great deal to prepare these people to work with handicapped soldiers.

We also attempt to explain the problem that often comes up, that has confused so many of us at times — I certainly include myself in this — of hostility apparently directed toward me by a soldier, or toward a hospital. The problem of hostility directed toward authority, and whoever happens to represent the authority becomes the object of the hostility, and how that hostility originates in the soldier, and how it can be gradually corrected by treatment of the man's illness, of which the hostility is a sympton, and we feel that the essential treatment there that reconditioning provides is the rebuilding in that man's subconscious mind of the concept of beneficent authority again, which he carried with him out of childhood when his father was surrogate.

I think that this is the fundamental concept that we all have to have about this thing: that if you get an eager beaver, a soldier that thinks you are a great guy, loves all the officers on the post, very enthusiastic about

everything in reconditioning, you discharge him back to duty, he is cured. He has recovered. He is a well man. He doesn't need your treatment. The eager beaver is the fellow that doesn't need reconditioning. It is the man that has got this problem of hostility until he can't get along with his own barracks mates, that he hates a Private First Class and from there on up to a General, that needs reconditioning, and that as he is reconditioned, he develops respect and understanding of leadership and authority.

On that basis we recommend that reconditioning programs be set up with an element of participation that is regulated and controlled and enforced, that it must be understanding participation for enforcement, it must be enforced. That is constantly demonstrating to the man that is working in his behalf, but that to let the man attempt to get well without adjusting to authority is not to treat him at all.

I also try to point out to the students that a patient in a military hospital is in a situation that is unequalled any place else in the world that I know of. I have never known of a hospital patient in civilian life who didn't have to pay any hospital bill, whose salary went on just the same, whose seniority went on just the same -- I have seen a few men promoted while patients in the hospital -- I am sure we all have -- who had no worries in the world, was ethically free in his ethical thinking of any responsibility while he was a patient in that hospital. It just doesn't exist any place else except in mental hospitals in civilian life, and there you don't pay them and you don't promote them. But it does in the Army, and you have to bring them into this hospital to make a normal situation that matches with the rest of society with some responsibility. How is it that a man is paid while he is a petient in the hospital or promoted while he is in the hospital? His hospital days are duty days. He is doing duty, and he certainly can be asked to do duty to the extent of his capacity while a patient in a hospital. The doctor has to determine what his capacities are.

We talk a little bit about psychosis one hour, just to give them a concept of the difference between psychosis, between the people who would be declared legally insane, and psychoneurosis, and we also tried to make a distinction between the legal concept of insanity and the medical concept of major mental illness or psychosis. Then we talk about organic lesions of the central nervous system, we give them some concept of what nerve regeneration means, the many months it takes and why, so that someone doesn't get the idea that that must have been an awful bad surgeon that took 18 months to have this nerve regenerate. We tell them a little bit about the organic basis for aphasia, paralyses and the degeneration in the character of the individual that occurs after extensive cerebral injury.

We also show a British film called "Psychiatry in Action," which outlines very closely the program that we have heard outlined in the last two days for our convalescent hospitals.

The third part of medical orientation is devoted to illnesses other than those of the central nervous system, and here we talk and teach of fractures and their reconditioning. We cover the fractures of the main bones of the body, we cover the fractures that occur in the minor bones of the body that are peculiar to the military, such as the Marsh fracture and the navicular, which, I believe, is more frequest in the Army than in civilian life.

We quote the policy laid down in 1940 by the British Orthopedic Association and its standing committee on fractures. This is it: "Active exercise and rehabilitation must begin on the day that active surgical treatment begins, that is on the first day. Some joints may need to be immobilized but every other joint is actively exercised and fundamental activity is thereby maintained.

A brief explanation of how fractures heal is given, and the importance of injury to soft parts that occurs with fracture in the final prognosis of the case.

An hour's lecture is devoted to the more common orthopedic problems that occur in military practice. A little explanation is made of ruptures of the vertebral disk, a little of the mystery taken away from it probably, we hope.

Then, we speak of abdominal wounds and their reconditioning, of the principle of healing of tissues, of how calisthenics can be managed without putting stress on those parts, and then we give a lecture on the difference in medical illnesses between the acute infectious diseases and the long chronic illnesses, and try to give a man some concept of why it may take a patient two months to get over meningitis, six months to two years to get over severe malaria, giving them a little concept of what variation there is in men and in disease.

The last lecture on this series is on the physical profile plan. We feel that a physical reconditioning officer and an educational reconditioning officer can often be of great benefit to a profile officer or to a dispositon board in describing what he has actually seen this man do and found him capable of doing in the gymnasium and on the playing field and in evaluating and assigning him a physical profile number.

Lastly, it is pointed out that no man should be hospitalized a single day beyond his medical need or point of maximum benefit for the sake of reconditioning, but maximum benefit means psychological adjustment as well as physical recovery.

The period is now open to questions and discussion, and if you will, at first, I would like to have them directed along the lines of the school. We have trained people for you. We haven't trained them all well. We think our training program has gotten better, class by class, but we are working for you and we would certainly like to know the areas that you find our graduates deficient in. Will someone please start?

COL. STINE: I have noticed -- it may be local, it may be general in both the enlisted and the officer physical training men a lack of insight into the application of all this physical training that they get to the specific disability of orthopedic patients. In other words, they are swell when it comes to playing games and directing games and directing athletics and directing exercises, but they don't understand the application of all this to specific remedial exercises. For example, I went into my remedial gym one afternoon and I saw an officer patient who had a flexion deformity. He was able to flex his leg at the knee about 15 degrees, and that is all. Well, he was doing squat bends. Now, granted, I stopped it immediately, and it was wrong, but I asked the physical training officer why this man was doing knee bends. He said, "Well, to loosen up that knee joint." He had no realization of the concept of synergistic action of muscles, and the muscle balance of the muscles of the body -- of the groups of muscles of the body -- and I believe that it might be, if that is a common experience of other men, it might be well for the schools, both here and at Fort Lewis to emphasize near the end of their program the application of all of these exercises to the various synergistic muscle groups and get over the concept that a frozen joint, so-called, is not a pathological joint, it is a pathological balance of the various muscle groups that activate that joint.

COL. JENSEN: Thank you, Colonel. What medical officer prescribed squat bends for that patient? Are there other comments along this line? Please let's have them. Shades of Mr. Pennock. I don't know a better teacher and I never saw one work harder at just this problem. We have a medical officer in the gymnasium with the educational reconditioning personnel, because we have a good many limited service personnel there. They make better material for teaching the technique of calesthenics to handicapped personnel, on some of these points, and we have the medical officer with the physical reconditioning students some of the time. We could probably do that more and I think it is worth very deep consideration.

May I have another comment on the school? This is very helpful. I will surely try to do more about your problem. I think it is probably more common than you alone have indicated.

COL. CUTLER: I haven't had very much to say but I would like just to make a final comment on the organization that we have seen, and the way the training program has been implemented. I think that those of us who have

watched this proceeding with a critical eye, and with interest as to its ultimate application to our patients from the professional point of view have been impressed with two things: first, that your school is giving to the men who are brought to you for training a fundamental and sound basic understanding of the problems of the patient as distinguished from the healthy individual who is not in need of physical rehabilitation.

I am very much impressed by that fact and by the scope of the program, which, seems to me to be extraordinarily thorough and basically sound.

I would like to suggest just one word of caution. That is, that when the men leave this organization they are not impressed with the idea that they have learned all there is to know about physical reconditioning; that, after all, it is a medical problem to be guided by medical men, that there are variations in individuals, and that in each instance the program must be dictated by the individual whose responsibility that patient's welfare is, in the final analysis, and that they must be guided by the decisions of the medical officer.

I think it would be well to convey to these men, as you undoubtedly do, that the medical officer is the man who will utilize their acquired abilities to his advantage and to the advantage of the patient to the fullest extent, and that he is willing and eager to increase their fund of information and to guide them in the performance of their duties, but it seems to me that those two authorities are the last ones, so that they will not be forgotten, which should be impressed upon the men: that here we have given you a basic training to permit you to understand the work you are about to do, to permit you to apply the techniques which are important in the performance of your work, and that from this point on your instructions will be by experience by the precept of the medical officers and specifically under the direction and control of the medical officer who holds the final responsibility.

COL. JENSEN: Thank you, Col. Cutler. I am very glad my staff was here to hear that. I can assure you I do think that we can spend some time and consideration on how better to make that concept really live in these men's minds as they leave. Are there any other comments?

MAJOR ESSLINGER: A few words about the school at Fort Lewis. As you all know, that is a school where the physical reconditioning instructors are trained. That is a six week course. It follows along very closely the physical reconditioning curriculum here at the school. However, having six weeks, they are able to do a much better job in certain areas with 50 percent more time. That school out there, we regret, is so far away. I know many of you have asked why it couldn't be located more centrally. That decision was made in higher headquarters.

I think an equally good job is done at Fort Lewis as is done here. We have pursued every effort to make both of these schools the best that we possibly could.

Now, in the field of physical education there has been no precedent of this type of job that the physical reconditioning officer and instructor had to do. I know that we have had many men come down here to this school, who have had very advanced training and experience in physical education, and some of them have felt that perhaps they ought to take the educational reconditioning course because they had an exceptional background previously, but if they were going into physical reconditioning work, I have steadfastly insisted that they do take the physical reconditioning course here because it was so new and different, and I am very confident that any physical reconditioning instructor or officer could not help but benefit greatly if he came to either of these two schools.

From my observation out in the field — and I know that that is borne out by every one of the Service Command Consultants, the best programs are invariably in those installations where the personnel have been school-trained. At least a number of them have been school-trained. Sometimes when I go out to the hospitals, I try to sell the school, and I very frequently get the argument, "Well, why not send an officer down there to Lexington and let him

conduct an inservice training program for the remaining officers and enlisted men when he gets back? Then you won't lose all the rest of the staff for that period of time."

Well, I think the answer is quite obvious. No hospital could possibly duplicate the training that is given here and the training that is given at Fort Lewis. You do need in-service training program constantly, but to hope that by such a procedure you can duplicate what is given here, I think is entirely fallacious. Frankly, if I were a hospital commander or a chief of reconditioning or service command reconditioning officer, I would make every effort to get every man that I could here to this school or Fort Lewis. I think that is the best way — the easiest way — to help solve your problems. I think that goes for educational reconditioning as well as physical reconditioning.

I know what problems you have in regard to your personnel. You don't have enough men and it is very difficult to send them. But somehow or other, if I were in a hospital, I would try to work 20 hours a day so I could manage some way or other to get this personnel to school, because I know they will do a better job for you when they get back.

I would like to comment just a moment too on the point that Col. Stine raised. I am confident that that is true. I think a reason for it is this: when it comes to teaching anatomy and kinesiology, physiology of exercise, Mr. Pennock is faced with the problem of having medical officers in his class and men that have never had a college hour in anatomy or kinesiology or physiology before. He has a tremendous lot of previous background in his class and I am pretty sure that he has to hit a middle course, and four weeks is all too little time for him and Col. Jensen and the rest of his staff to do very much of a job in preparing these men as experts, or even approaching it, in this area of remedial exercise. Remember, however, the medical officer prescribes the exercises for his patients and the reconditioning personnel execute the prescription!

I wish this school could be much longer, so they could do a much better job. As you all realize, this field of remedial exercise is the province of the orthopedic service, the physiotherapist, but the physical reconditioning personnel are called upon very often to assist — there is a shortage of physiotherapists — and in those instances I think the best solution to the problem — is the doctor's prescription.

COL. JENSEN: Thank you, Major Esslinger.

Col. Thorndike.

COL. THORNDIKE: I would like to remind those present that there is a very acute shortage in the field of this trained personnel, and that we have advised ASF personnel, through our own personnel service, that we need 200 physical reconditioning officers at once — in other words, the enrollment of the next two schools completed. We will need another 200, it is estimated, to absorb in the changeover that will be necessary in the program for Class 4 and 3 in General Hospitals, counting all those that have been qualified, and that is what I am speaking of, and not those who have not been to school that are in the program.

I learned today that the Air Force occupies 50 percent of the enrollment in the educational reconditioning courses in this school, and that that school is 149 enrollees out of 150. I think that it is up to us to keep these schools full — certainly, for the next three months — with as many personnel as we can, if we are going to meet this program and make it click, as all higher echelons expect.

COL. JENSEN: Thank you, Col. Thorndike.

May I say a word along that line: General Dalton has been very, very gracious to us. We are all in the same business — you and I. This school is our school. He has maintained a staff here that the enrollment in this

school has not justified, with the hope that as the program got on its feet in the field, the staff would be adequately utilized. We cannot justify the present staff we have if we cannot have enrollment, and I doubt very much that we can justify the continuation of these training programs unless we have enrollment. I think probably Major Cruze could say something about that.

MAJOR CRUZE: I would say this: that in our office we have made -- just completed -- a survey of the need for the personnel trained at this school, and at Fort Lewis. That is, not only the need in this particular program but the need in all programs. The results of that study indicate that even if your quotas are always filled -- and they haven't been -- that there would still be a rather tremendous shortage of trained personnel for this type of work. I think I can assure you that there is going to be tremendous pressure brought to bear to fill the quotas which exist -- not only to fill the quotas which exist but probably increase the quotas considerably, and to fill these increased quotas.

I want to say this -- to make this one other remark -- with reference to what I said yesterday concerning in-service, or instructor guidance, training. Those in-service training programs or instructor guidance programs, are conducted on the assumption that your instructors are already well-trained personnel and that this in-service training is necessary to keep them up to a peak of efficiency.

It is not assumed that your instructor guidance program or your instructor training program will carry the load of training these personnel except in emergencies where something must be done and something must be done in a hurry. These instructor guidance programs are designed for personnel who have been trained, to keep them on their toes and to keep them up to date.

COL. JENSEN: Does anyone have any questions?

MAJOR BRISCOE: I have noticed a slight tendency, as I visited in the field, for people to recognize readily the need for training physical education officers, because that is an obvious field, and it is relatively simple to see the mission of training to forms of their tests. Education, however, which is more elucive abstract, can in many ways be difficult. It seems harder to see the reason or the need for training. I think there is a very great danger in that -- this thinking on the part of all of us. I would like to second very strongly what Major Esslinger said, and have you apply it also to the educational reconditioning. I don't know if it is appropriate for me to make this second remark, but I should like to do it. I should like to thank you, Col. Jensen, and your staff personally, on behalf of the educational reconditioning branch of the Surgeon General's office, for the very fine support you have given to our program. I know that you camedown here with practically no staff. Where you got them, I don't know. How you carried on the first few months, I am quite at a loss to know. But you did. You have done a fine job for us and we appreciate it.

COL. JENSEN: Thank you.

Major Lorenzen.

MAJOR LORENZEN: It is with reluctance that I see this conference drawing to a close, and I would like to finish off my part in it with a plea to the gentlemen from service command headquarters to try to keep us posted on the directives and material that you distribute to your hospitals. We have the problem here, of course, of training people for nine service commands and the military district of Washington, and if we could be kept informed of that which you distribute to your hospitals, we I believe, can do a better job than we are doing now.

COL. JENSEN: I want to second that. I want to re-emphasize that we are running the school for you, and that we need your help. You are the testers, the evaluators of the product and we need your help.

Are there any other comments at this time?

(No response.)

COL. JENSEN: I want to just ask Major Juster to walk up here for just a

few minutes, and then Col. Quarterman to close.

Major Juster has a very interesting observation to make about participation control. It goes back to where I was talking about our feeling about disciplinary management of reconditioning.

Major Juster, from the Mitchell General Hospital, Camp Lockett.

MAJOR JUSTER: Not infrequently do we run into the problem of lack of participation, and we feel that it is due to the inability on the part of the patient to concentrate on the task that he has chosen. So we have adopted a system whereby a constant check is kept on the man during the course of the working day.

In the first place, we have established standard operating procedures for processing convalescent soldiers, in which we have a routing slip. From the time that he arrives in camp until he is put into the program, there are seven places that he must go which are signed after he has appeared and the last place is the chaplain and this, by the way, helps keep tabs on the man to be sure that he goes through the process of the screening and the interview with the educational officer, classification officer, and so forth.

Now, one week before the classes begin, which is based on a four-week program of 20 hours, we publish a brochure describing each course, giving the man an opportunity to peruse them and have him make his choice.

Now, the scheduling officer in filling out the program, does it in quadruplicate: one for the patient, one for his medical advisor, one for his company commander, and one in the central file of the scheduling officer. So that when a patient is required to be at a given place, the medical advisor, the company commander, knows exactly when the man has the free time, and if it is suitable for that man to appear at his free time, he will try to make the appointment in the patient's free time. If not, he can have the patient at any time, but by this process we find that there is the least amount of interference with the program. We try to get the appointment made 48 hours in advance, if possible. Patients can be seen at any time. We know exactly where they are. Now, wherever the patient goes, whatever course he is taking, there is an attendance slip which is filled out by the instructors. At the end of the day the instructor submits a slip of absence, dropped, and new students. These are all sent to the scheduling officer, and he compiles them and he sends a consolidated report on the absentees to the company commander and on it is room for the reason or reasons for absence. Failure to appear at a class, lack of reason, company punishment is instituted. Now, this may sound like regimentation, but not in the sense as one of the correspondents tries to infer. We have found that the patients are sincere if we are sincere, and that if they know that we are doing this program for their good, they will accept their punishment, and in very few instances have we had any difficulty. By this method we have had excellent participation and the least amount of griping, and before we instituted this system we had poor attendance.

COL. JENSEN: I think this brings out one point which we can end up on very well. Major Juster said that if the patient was convinced that you were sincere, he was, too. The average American soldier is a pretty good boy. He means business and he doesn't want to have his time wasted, in the final analysis.

Now, if you are going to demand — and I think we need to — participation, you have got to have the quality of instruction and leadership that warrants the participation or you are certainly in trouble, and the best people we can find, with the best training we have time to give them, are none too good for this kind of a job.

Col. Quarterman. We still haven't gotten Col. Quarterman reconditioned.

COL. QUARTERMAN: Col. Jensen, Col. Thorndike, gentlemen of the conference. I am either on a bad spot on the program or a very good one. I am the last speaker, anyhow. I had my thunder all stolen by four or five of the last speakers. I was going to leave with you one thought only: that in developing what we thought was a pretty good program, and conducting several classes in reconditioning

here, I became very much discouraged, and still was, until the Major said something about an increased enrollment, for this reason: I felt that we had on our hands a dying duck. There is no question about it. We weren't getting but about one-third of the enrollment, and that was decreasing, and still is, as a matter of fact, in the current course. And I well know from many discussions with General Dalton that these courses will never last unless we have got students in here. There is no use having a good program and a fine staff interested and enthusiastic, and no students to teach, and that is exactly what we are up against.

We finally broke through a little bit after having about 10 officers and about half as many enlisted personnel as we were authorized or had to pass before by having a few material increases in the number of enlisted WACs.

That is about all that has kept it going.

Now, we have gotten a few proselyted by visitors like Esslinger and Briscoe and Dettrick and others around who begged and borrowed and stole a few students, but, as a matter of actual fact, you had a dying school on your hands, there is no question about it, and it still in, unless there is something done about it, because I know the thing won't last.

Now, Col. Thorndike and I were in talking to the Surgeon General about three weeks ago and he is definitely interested in reconditioning. There was no question in my mind about that when he got through because he authorized Col. Thorndike to send a radio out extending invitations to theater commanders to send in students into the schools. I don't know whether it has ever been implemented or not, but that was his reaction to the thing and I don't know now whether I am talking to the right people or not, but I may be talking to some who have the ears of the people who could do something about it.

I also know that there is a tendency on the part of the hospitals not to send students because of the need for men to work in the hospital but, as I understand it, the people who have had the training do a better job in the field, which would indicate that they should have the training. If they don't, they ought to kill the school.

Now, if you get the students here, I will guarantee that the staff will be on the ball, that the program will follow the directives of the Surgeon General and be improved as far as possible and that we will do the best we can to keep the students in line and get them out of here well trained so far as the curriculum and the program and the time will permit, but there is no use fooling with something that you don't back or that you don't get students here for.

Now, for my benediction, I am awfully glad that we have had the pleasure of having you here. I hope you have enjoyed the conference and gained from it. I hope you will go back to your stations feeling that you have gained and that the program will be pushed, because I feel that it really has a tremendous place, and based on what is happening in Europe now and in the Southwest Pacific and the Pacific Area, there is no question in my mind but what there is going to be plenty of reconditioning to do.

I am glad you were here. I hope you enjoyed it.

(Applause.)

COL. JENSEN: Before you leave, I want to correct just one idea. You heard the one hour of instruction given on industrial therapy in the entire curriculum. I want you to understand that as you go away. That is only one hour that is given.

(Whereupon, at 5:45 o'clock p. m., the conference was concluded.)

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